

## **Department of Electroencephalography**

Fields marked \* are mandatory

					NUIC No*:
Name*:			DoB*:		NHS No*:
Address*:					
Tel No*:	Home:	Mobile:			
	Awake EEG	Sleep EEG	Urg	ent?	
Test Type*				ase give reasoı	1:
<b>0</b> 14 4		Tel No:	Fax	:	
Consultant					
Name & Email*					
Reason for					
Request /					
-					
Question*?:	Clinical biotomy	arranative of moore	. than 1 .	المعادما مما	
Routine EEG –					zure that is epileptic in
Please tick	<u>origin</u> (or 1 seizure with increased predisposition for subsequent seizures).				
indication* (as	To help determine <b>seizure type</b> /epilepsy syndrome.				
per NICE	Repeat EEG- please state reason				
guidance)					
Diagnosis:					
Clinical					
summary*					
(include family					
history)					
Description of					Frequency
Attacks*	1.				<u> </u>
	1.				
	2.				
	3.				
Current					
Medication*:					
	(Please note parents will i	need to hring their sun	nly of eme	raency medication	with them if applicable)
	(1 loade flote parefite will f		pry or orrior	geney mealeation	with them is applicable)
Any recent					
medication					
changes*?					
Imaging					
Previous EEGs					
Melatonin :	2mg for children unde	er 3 years/3mg un	der 6 yea	rs/6mg for ove	r 6 years
(If Required)	(Please note Melatoni				
1. 2.7	so that parents can b				, ,

**Requesting Doctor:** 

Date: