Department of Electroencephalography

EEG Request Form: Maidstone & Tunbridge Wells

Tel: 01342 831273
Email: NCYPWE.Referrals@nhs.net

Fields marked * are mandatory

Name*:		**DoB*:**		**NHS No***:
Address*:				
Tel No*:	**Home:**		**Mobile:**	
Test Type*	Awake EEG	Sleep EEG	Urgent? Please give reason:	
Consultant Name & Email*		Tel No:	Fax:	
Reason for Request / Question*? :				
Routine EEG – Please tick indication* (as per NICE guidance)	☐ **Clinical history** suggestive of more than 1 unprovoked seizure that is epileptic in origin (or 1 seizure with increased predisposition for subsequent seizures). ☐ To help determine **seizure type**/epilepsy syndrome. ☐ **Repeat EEG**- please state reason…….			
Diagnosis:				
Clinical summary* (include family history)				
Description of Attacks*	Frequency 1.			
	2.			
	3.			
Current Medication*:	*(Please note parents will need to bring their supply of emergency medication with them if applicable)*			
Any recent medication changes*?				
Imaging				
Previous EEGs				
Melatonin : (If Required)	2mg for children under 3 years/3mg under 6 years/6mg for over 6 years ***(Please note Melatonin will need to be prescribed and dispensed by you beforehand so that parents can bring it to the EEG appointment)***			

Requesting Doctor: **Date:**