



**TOWNSVILLE  
NEUROSCIENCES**

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Patients Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: H \_\_\_\_\_ M \_\_\_\_\_

Request: *(Please mark circle)*

- EEG
- VER
- EEG TELEMETRY
- SLEEP DEPRIVED EEG
- NCS / EMG
- REPETITIVE NERVE STIMULATION

PROVISIONAL DIAGNOSIS: \_\_\_\_\_

Clinical Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referring Doctor (Name): \_\_\_\_\_

Signature: \_\_\_\_\_ Provider No: \_\_\_\_\_

Date: \_\_\_\_\_

**If a sleep deprived EEG is requested it is advised that you do DO NOT drive,  
but arrange alternative transport to and from your appointment.**