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easternhealth
GREAT HEALTH AND WELLBEING

Neuro Diagnostic Unit

Building B, Ground Floor
Box Hill Hospital
51 Nelson Road, Box Hill 3128
Tel: 9895 4639
Fax: 9895 4610
Email: ndu@easternhealth.org.au

Patient Details (or patient label) DOB_____

Surname_____ First Name_____

Address_____

_____Postcode_____Tel_____

Request for:

EEG

Routine EEG ☐

Sleep Deprivation EEG ☐

_____

ELECTROPHYSIOLOGY

Routine Nerve Conduction studies/EMG ☐

MUST Complete the following:

- Is patient on Warfarin/anti-coagulant? YES/NO
- Does Patient have a pacemaker? YES/NO

Evoked responses (specify) _____ ☐

Clinical Details

Referring Doctor MUST complete this section

Name_____

Address_____

_____

Tel_____Fax_____ Date_____

Signed_____Provider No_____