



NEUROSCIENCE LABORATORY REQUEST

Level 6 North, Austin Hospital Tower
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UR:..... DOB:...../...../.....
Name:.....
Address:.....
.....
Ph:.....

OP IP **WARD:**.....

ULTRASOUND

- Carotid and Vertebral Ultrasound Subclavian Steal
- Transcranial Doppler and Duplex Imaging
- Neuromuscular Ultrasound (eg: Carpal Tunnel Syndrome)

ELECTROENCEPHALOGRAPHY (EEG):

- Routine EEG
- Sleep deprived study
- Day monitoring - Ambulatory EEG

EMG/NERVE CONDUCTION STUDIES:

- Routine EMG/NCS
- Carpal Tunnel Assessment (NCS +/- Ultrasound)
- Myasthenia (Repetitive Stimulation Single Fibre EMG)

EVOKE POTENTIALS:

- Visual Evoked Responses (VER) Brainstem Auditory Evoked Potentials
- Somatosensory Evoked Responses (SEP) Upper Limb Lower Limb
- Transcranial Magnetic Stimulation (TMS)

CLINICAL DETAILS: (see over for Map)

Requesting Doctor:

Name: (Please Print):..... **Date:**...../...../.....

Signature:..... **Prov. No:**.....

Address:.....

Cc:.....