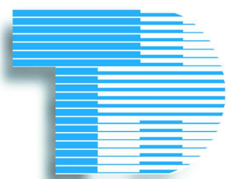

# *EEG Laboratory*

## *Timmins & District Hospital*

**John P. Larche**
Medical Imaging and Cardiopulmonary Department
**700 Ross Avenue East, Timmins, ON P4N 8P2**
**Tel**: 705-267-6313 **Fax**: 705-267-6346

| **Name:** | | | | **Date of Birth** | | |
|---|---|---|---|---|---|---|
| **Address:** | | **Age:** | | **Day** | **Month** | **Year** |
| | | **Sex:** | | | | |
| **Health Card:** | | **Postal Code:** | | | | |
| **Telephone** | **Residence:** | | **Work:** | | | |

| **Out Patient:** | **In Patient:** | **Room #: ______** |
|---|---|---|
| **Reason for EEG:** | | |
| | | |
| | | |
| **Current Medications:** | | |
| **Tentative Diagnosis:** | | |
| | | |
| **Special date/time requested:** | | |
| **EEG #:** | **Date of previous:** | |

| **SLEEP DEPRIVATION: YES NO** |
|---|
| **AMBULATORY: YES NO** |
| **SPECIAL NEEDS:** |

| **Referring Physician:** | **Date:** |
|---|---|
| **Signature of Referring Physician:** | |
| **Copy to:** | |

**FOR HOSPITAL USE ONLY**

| **Date Received:** | **Date of Appointment:** |
|---|---|
| | **Time:** |

PCS-1243-0516

HDORD