Routine EEG Referral Form

Test: ☐ 30 minute routine EEG ☐ Sleep-deprived EEG

Priority: ☐ ASAP ☐ At patient's convenience

Type of invoice: ☐ Medicare mixed billing ☐ Private pay ☐ Workers Compensation ☐ Defence Force ☐ Other

For more information: seermedical.com/au/fees

This section must be completed for the referral to be processed. By submitting this referral, I confirm that this request complies with the MBS criteria for Item 11000.

Patient details

Please use BLOCK/CAPITAL letters

Name ..... D.O.B. (min 2y.o.) .....

Email ..... Phone .....

Address ..... Gender .....

Medicare no. ..... Expiration .....

Referrer details

Email .....

If reports and notifications should be sent to another healthcare provider in addition to the referring clinician, please fill in the details below:

Email .....

Monitoring details

Why is a routine EEG required?

Description of seizure/event

Frequency of seizure/event

Additional clinical information

Does the patient have an epilepsy diagnosis?

☐ Yes ☐ No

Has the patient had previous EEG monitoring?

☐ Yes ☐ No

Prior test results / Other previous investigations

Epilepsy medication

Non-epilepsy medication

Medical history

- ☐ Acute respiratory distress syndrome (ARDS)
- ☐ Asthma
- ☐ Cerebral vascular accidents (CVA)
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Increased intracranial pressure
- ☐ Moya Moya disease
- ☐ Myocardial infection (MI)
- ☐ On supplemental oxygen
- ☐ Pregnancy (third trimester 24 weeks / 6 months)
- ☐ Sickle cell anaemia
- ☐ Surgery (including transplants)
- ☐ Transient ischaemic attacks (TIA)