Patient Name: _____ DOB: _____/_____/___

Patient Address:_____

Medicare Number: _____

Phone: _____ UR: _____

EEG (Electroencephalograph)

- ☐ EEG (Electroencephalograph)
- ☐ Sleep Deprived Electroencephalogram

Clinical Indications:

_____

_____

_____

Current medication (please provide a current list):

_____

REFERRING DOCTOR

Name: _____Provider Number: _____

Signature: _____

Date: ____/_____/_____

Scan the QR code for access to EEG patient information

Please send your request to:

COPIES TO

EEG Bendigo Health
100 Barnard Street
Bendigo 3552
P: 54548093 F: 54548020
E: cardiology@bendigohealth.org.au