Hartford HealthCare

Ayer Neuroscience Institute

EEG Referral Form

Medical Office Building, Suite 815
85 Seymour St, Hartford CT 06102
Phone: 860.972.3621
Fax: 860.545.5003

Patient Name: ____. Date of Birth: ____

Phone number: _______________________________________. Alternative Phone Number: __________________________

Please select one type of EEG (in bold)

☐ **Outpatient EEG:**

1. Routine EEG:
   - Length: Standard ☐ > 60 minutes ☐
   - Sleep: Standard ☐ Sleep Deprived ☐
   - Indication: Seizure ☐ Epilepsy ☐ Other______________________
2. Ambulatory EEG
   - a) Has the patient had an EEG? Yes ☐ No ☐ Unknown ☐
   - b) If Yes, was it an inpatient, multiple day duration EEG (EMU)? Yes ☐ No ☐ Unknown ☐
   - c) Where was the prior EEG performed? _________________________________
   - d) Duration: 24 hour ☐ 48 hour ☐ 72 hour ☐

☐ **Epilepsy Monitoring Unit Admission Referral:**

3. You are a neurologist and plan to continue caring for this patient after the EMU admission? Yes ☐ No ☐
4. Does the patient have medication refractory epilepsy? Yes ☐ No ☐ Unknown ☐
5. Has the patient had an EEG? Yes ☐ No ☐ Unknown ☐
   - a) If Yes, was it an inpatient, multiple day duration EEG (EMU)? Yes ☐ No ☐ Unknown ☐
   - b) Where was the prior EEG performed?
     ____
6. Has the patient had a brain MRI or Head CT scan? Yes ☐ No ☐ Unknown ☐
   - a) If Yes, was the MRI/CT scan abnormal? Yes ☐ No ☐ Unknown ☐
   - b) Where was the prior MRI/CT performed? ____________________________________

Referring Provider:

Name (please print): ______________________________ Signature: ____

Phone: ____. Fax: ____