

TRANSMITTER:
MOP: 1 35 36 37 _____
ELECTRODE: Cap Disk



- TRANSFER
- FAX
- EMAIL
- After-Hours

CODE:	PATIENT DATA	DATE:
Hospital:	Activations:	Time: Station:
City / State:	HV Breaths:	EEG#: Rec Tech:
Patient:		Tech:
Age: DOB:	Sleep Dep.	Dr. Name:
Sex: M F Hand: R L Room: IP OP	Photic Stim.	Meal: Hrs:

Medication: _____

Consciousness: Awake / Alert	Asleep	Drowsy	Lethargic	Confused	Stuporous	Comatose
Cooperation: Good	Agitated	Restless	Poor			
Diagnosis: SZ Dis	Sync	ADD	TIA / CVA	COPD	Memory Loss	Other:

Patient History: _____

Previous EEG Date: _____ Report: _____

COMMENTS:

This is the patient information sheet required to do an EEG. When you have an EEG, please fill out this sheet completely and fax it to **281-821-6401**. Make sure that your **ACCOUNT CODE** and **HOSPITAL NAME** are on the sheet (please do not abbreviate your hospital name). Thank you for your help this will save all of us valuable time on all EEG's.

Thank You,

Management