

Neurophysiology Referral

Department of Neurology & Neurophysiology

Laboratory location: *Sunshine Hospital*
176 Furlong Rd, St Albans
Ground Floor
Acute Services Building

All referrals & enquiries: Phone 03 8395 9075 Fax 03 8345 4018
Email WesternHealthNeurology@wh.org.au

Surname

First name

UR number

Sex M F DOB/...../.....

Address Suburb Postcode

Phone (mobile) Phone (home)

Referring Doctor Provider number

Address Suburb Postcode.....

Referral date/...../.....

Email copy of report to (referring doctor email)

Review scheduled at ☐ External rooms ☐ Specialist Clinics (Neurology) ☐ Other..... Review Date...../...../.....

Tests required	Appointment type	Priority
☐ EEG – routine	☐ Outpatient	☐ Non-urgent
☐ EEG – sleep deprived	☐ Inpatient	☐ URGENT
☐ EEG – extended video EEG telemetry		☐ Interpreter required
- Hospital admission 2 – 4 days - Neurologist referral only		Language.....
☐ Evoked response – visual	Other notes:.....	
☐ Evoked response – auditory		
☐ Evoked response – SSEP		
☐ EMG – nerve conduction study		
☐ Carpal Tunnel Syndrome (only)		

Clinical indication and question (Please provide brief history).....

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Previous tests.....

Current medication.....

Mobility issues

- If patient requires assistance transferring to recliner chair / examination couch, please bring family member / friend / carer to appointment

Does the patient have transport requirements? ☐ No ☐ Yes

If so, what bookings have been made?

Is there a history of aggression? (for safety purpose only, will not affect acceptance of referral)

☐ No ☐ Yes ☐ Verbal ☐ Physical ☐ Carer required

Signed Date/...../.....

****Please note: Referral will not be accepted without referring doctor's name, provider number, signature and date.