Western Health

(affix patient label – or print clearly)

Neurophysiology Referral

Department of Neurology & Neurophysiology

Surname .....

First name .....

UR number .....

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

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

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		
• *Hospital admission 2 – 4 days*		☐ Interpreter required
• *Neurologist referral only*		*Language*.....
☐ Evoked response – visual		
☐ Evoked response – auditory	Other notes:……	
☐ 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** ...../...../.....

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