TRANSMITTER:
MOP: 1 35 36 37 ____
Electrodes: Cap Disk

☐ TRANSFER
☐ STAT

CODE: **DATE:**

Hospital:	***CIRCLE Actions***	Time:	Station:
City / State:	<u>Activations:</u>	EEG#:	Rec Tech:
Patient:	HV Breaths:	Hosp Tech:	
Age: DOB:	Sleep Dep.	Dr. Name:	
Sex: M F Hand: R L Room: IP OP	Photic Stim.	Meal:	Hrs:

Medication: ______________________________

Status:	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 Hx: ______________________________

Previous EEG Date: Report:

FORM MUST BE FILLED OUT COMPLETELY FILLED OUT AND CIRCLE ANY INFORMATION THAT PERTAINS TO THIS TEST

<u>NOTICE:</u>

This is the patient information sheet is required to do an EEG. When you have an EEG, please fill out this sheet completely and fax it to ***<u>281-821-6401.</u>*** 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

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