Western Health

# Neurophysiology Referral

(affix patient label – or print clearly)

**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 9318 6342
**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** .........../.........../......... **Copy report to** ..................................................................................................................

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

**Tests required**

☐ EEG – routine
☐ EEG – sleep deprived
☐ EEG – extended video EEG telemetry

- *Hospital admission 2 – 4 days*
- *Neurologist referral only*

☐ Evoked response – visual
☐ Evoked response – auditory
☐ Evoked response – SSEP
☐ EMG – nerve conduction study
  ☐ Single Fibre
  ☐ Carpal Tunnel Syndrome (only)

**Appointment type**

☐ Outpatient
☐ Inpatient

**Priority**

☐ Non-urgent
☐ URGENT

☐ Interpreter required
*Language*...................................

Other notes:……………………………………………………………………….
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**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*

**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.**