NEUROPHYSIOLOGY LABORATORY
EEG/EVOKED POTENTILA INTAKE FORM

NAME: ____

DATE OF BIRTH: ____

SEX: MALE FEMALE

IS SLEEP TEST, IS PATIENT ACCOMPANIED: YES NO

NAME, ADDRESS AND TELEPHONE NUMBER OF REFERRING DOCTOR:

MEDICATIONS:

BRIEF DESCRIPTION OF PATIENT MEDICAL HISTORY:

-------------------------------------TECNICIANS USE ONLY---
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RECORDING CONDITIONS: Awake, alert, tense, relaxed, cooperative, disoriented, drowsy, asleep, coma, hyperactive.
ARTIFACT: (Muscle, movement, sweat, other __________________________)

UNIT# ____

TECHNICIAN: __________________________________

DOCTOR_______________________________________