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Dr Kavitha Kothur
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Paediatric Neurologist

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Name: Sex: Male Female

D.O.B: Address: Phone:

Email:

Procedure Requested (Please tick):

- Routine EEG Sleep-Deprived EEG
 Ambulatory EEG

Handedness: Right Left

Indication for EEG:

Relevant Clinical History:

Description of Seizure:

Frequency of Seizure: Daily / weekly / monthly / infrequent

Date of the last seizure:

Current medications:

Results of previous Investigations:

ECG :

EEG :

CT Scan:

MRI Scan:

Referring Doctor :

Address :

Phone :

Fax :

Email :

Date :

Provider Number :