Dr Kavitha Kothur

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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 : **Provider Number :**
Address :
Phone :
Fax :
Email :
Date :