

SOUTH EAST WALES CLINICAL NEUROPHYSIOLOGY SERVICE

ERG REFERRAL FORM

DATE RECEIVED:		Breach date:		
SURNAME	FIRSTNAME	CONSULTANT (Full surname)		
		REFERRING HOSPITAL		
		SPECIALTY/DEPT		
ADDRESS		DATE OF BIRTH	INPATIENT/ OUTPATIENT/ OTHER	WARD
POSTCODE				EXT No
HOSPITAL NUMBER		PATIENT TELEPHONE NUMBER		MR/MRS/MISS/ MS/DR/PROF
		NHS NUMBER		

PLEASE STATE PROVISIONAL DIAGNOSIS AND REASON FOR REFERRAL - PLEASE PROVIDE A COPY OF ORIGINAL CONSULTATION LETTER. THIS IS ESSENTIAL FOR ALL ERG REQUESTS.

I prescribe 1% tropicamide to be administered, 1 drop to each eye prior to dark adapting for 20 minutes.

Name of prescribing doctor _____ Signature _____ Date _____

To be completed on day of test:

Name of administering physiologist _____ Signature _____

Date of administration _____

ARE STAFF CONSIDERED TO BE AT RISK FROM THIS PATIENT? YES / NO

This information will be treated in strict confidence and will only be used to protect staff who may be at risk

THE TEST INVOLVES SKIN ABRASION. IS THERE A KNOWN OR SUSPECTED RISK OF HEPATITIS B/C, HIV, MRSA, JCD? IF YES, PLEASE SPECIFY.....

This information will be treated in strict confidence and will only be used to protect staff who may be at risk

ALL INFORMATION IS ESSENTIAL. INCOMPLETE FORMS WILL RESULT IN DELAYS TO PROCESSING THE REFERRAL AND MAY BE RETURNED

Only consultant medical staff can sign this form.

DATE.....

SIGNED.....

ERGs can only be requested by a consultant. Full clinical details, preferably the original consultant letter, will be required.

Children's ERG	Electroretinogram. Skin electrodes used. VEP performed simultaneously. Flash stimulus only. 1 hr duration approx. Patient concentration and cooperation required.
Adult ERG	Full electroretinogram with corneal thread electrodes including pattern and flash responses to white and blue light. White flicker and EOG. Requires mydriatics so patient unable to drive for 4 hours afterwards. Takes 2½ hrs approximately. Patient concentration and cooperation required.