



**AMBULATORY EEG RECORDING  
NON-VIDEO  
STUDY REPORT**

<b>PATIENT NAME</b>		<b>TEST DETAILS</b>	<b>EEG</b>
<b>DATE OF BIRTH</b>		<b>TEST DATES</b>	
<b>EEG TECHNICIAN</b>		<b>TEST DURATION</b>	
<b>REFERRING PHYSICIAN</b>		<b>STUDY NUMBER</b>	
<b>READING PHYSICIAN</b>			

<b>HISTORY:</b>
<b>TECHNICAL DESCRIPTION:</b>
<b>BACKGROUND EEG:</b>
<b>EKG:</b>
<b>PUSH BUTTON EVENTS:</b>
<b>VIDEO:</b>
<b>ICTAL EEG:</b>
<b>INTERICTAL (SPIKE) DETECTIONS:</b>
<b>AUTOMATED SEIZURE DETECTION FILES:</b>
<b>AUTOMATED TIME SAMPLES:</b>
<b>EEG INTERPRETATION:</b>

---

Doctor Name and Title