Routine and Ambulatory EEG Order Form

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Patient Contact Information

Name: ______________________________ DOB: ____________
Last First MI

Address: ______________________________
Number Street Apt.

____
City State ZIP

Home phone number: ____________ Cell phone number: ____________

For privacy, which is the number that you would prefer us to use? ____________

Primary Insurance ____________ Primary policy holder (e.g., spouse) ____________

Policy ID #____________ Group #:____________

DIAGNOSIS and CPT______________________________

Previous EEG Results ______________________________

CLINICAL OBJECTIVE

- ☐ Differential diagnosis
- ☐ Identification of seizure type
- ☐ Epileptic verse Non epileptic seizures
- ☐ Preoperative evaluation for epilepsy surgery
- ☐ Other

TEST REQUISITION (If not specified, we will perform a 72hr study)

Duration: ☐ Routine ☐ 24hrs ☐ 48hrs ☐ 72hrs

Location: ☐ Home ☐ Facility ☐ Other (please specify) ____________

REFERRING PHYSICIAN STATEMENT

- **I certify to the best of my knowledge; this test and any interpretation is medically necessary in order to diagnose this patient.**
- **I understand that this test and any interpretation provided are intended only to supplement my diagnosis of this patient's condition.**

Referring Physician Name: ______________________________

Phone number: ____________ Fax for EEG Reports: ____________

Physician /NP/PA Signature: ____________ Date: ____________