VIDEO AMBULATORY EEG EXPRESS ORDER FORM

Fax: 888-539-3001

❑ Providence ❑ Quincy

Patient Name ______________________________

Patient Address ______________________________

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Cell Phone ______________________________

Home Phone ______________________________

❑ *Male* ❑ *Female* *DOB* ____/____/____

Insurance ______________________ *ID #* ____________

PLEASE PROVIDE US WITH A COPY OF THE FRONT & BACK OF INSURANCE CARD, PATIENT DEMOGRAPHICS, CLINICAL NOTES & ROUTINE EEG REPORT

Referring Physician ______________________________

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Phone # ______________________________

Fax # ______________________________

NPI # ______________________________

REFERRING PHYSICIAN STATEMENT

I certify that I am referring the above named patient to United Neuro Diagnostics for long term neurophysiological monitoring using the Home Monitoring system. 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.

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PHYSICIAN SIGNATURE DATE

❑ ***Long Term Video Ambulatory EEG Length of Monitoring Requested (Check one)***

❑ *24 hours* ❑ *48 hours* ❑ *72 hours*

❑ ***Sleep Study CPT Code 95810***

CLINICAL HISTORY Check all that apply

❑	*General Noncorvulsive Epilepsy*	*G40.A01*
❑	*Partial Epilepsy with Impairment*	*G40.201*
❑	*Convulsion*	*R56.9*
❑	*Syncope*	*R55*
❑	*General Convulsive Epilepsy*	*G40.30*
❑	*Partial Epilepsy w/o impairment*	*G40.001*
❑	*Vertigo*	*R42*
❑	*Transient Ischemic Attack*	*435.30*

Primary Diagnosis ____________________

Secondary Diagnosis ____________________

Etiology ______________ ***ICD10*** ________

EEG History

❑ *REEG* ❑ *SDEEG* ❑ *A-EEG* ❑ *EMU*

RESULTS

❑ *Normal* ❑ *Slowing*

❑ *Abnormal Findings* ____________________

TEST OBJECTIVE

❑ *Differential Diagnosis* ❑ *Monitor Interictal*

❑ *Evaluate Epilepsy/Seizure Class*