UNITED NEURO DIAGNOSTICS LLC
A VIDEO AMBULATORY EEG COMPANY

VIDEO AMBULATORY EEG EXPRESS ORDER FORM

Fax: 888-539-3001

BROOKLYN
- ☐ Bay Ridge
- ☐ Park Slope

QUEENS
- ☐ Bayside

NASSAU
- ☐ Garden City

ROCKLAND
- ☐ Blauvelt

SUFFOLK
- ☐ Commack
- ☐ Shirley

NEW YORK CITY
- ☐ 199 Third Ave

ORANGE
- ☐ Middle Town

Patient Name _____

Patient Address _____

_____

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 _____

Address _____

_____

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.

_____

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 Nonconvulsive Epilepsy*	***G40.A01***
☐ *Partial Epilepsy with Impairment*	***G40.201***
☐ *Convulsion*	***R56.9***
☐ *Syncope*	***R55***
☐ *General Convulsive Epilepsy*	***G40.309***
☐ *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*