AMBULATORY/ROUTINE EEG ORDER FORM

Fax: 832-218-6416 / Phone: 281-949-6991

Patient Name: _____ DOB:___ /___ /___ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance: _____ ID# _____ Group # _____

CLINICAL HISTORY

Diagnosis: _____

PROCEDURE ORDERED

All Procedures include ECG (93268)

❑ Monitored Video EEG

_____ 24 hours _____ 48 hour _____ 72 hour _____ 96 hour _____ 120 hour

❑ Routine EEG with Video

_____ 20+ mins (95816) _____ 41-60mins (95812) _____ 61+ mins (95813)

❑ Nocturnal EEG Recording with Video (All night) (95857)

Physicians Name: _____

Physicians Signature: _____

NPI#: _____ Office Phone: _____ Office Fax: _____

Physician Statement: I certify that I am referring the above named patient for an Electroencephalogram (EEG), or video long term EEG. This test is medically necessary in order to diagnose the patient. I understand that the diagnostic provider will not provide a diagnosis nor will they recommend treatment for this patient.

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