

EEG/AMBULATORY EEG REQUEST FORM

PATIENT'S NAME: _____ DATE OF BIRTH: _____
UNIT#: _____ PHONE#: _____

PATIENT ADDRESS: _____

DIAGNOSIS: _____

DIAGNOSIS CODE: _____

INSURANCE: _____ INS. ID#: _____

INSURANCE ADDRESS: _____

REFERRING PHYSICIAN: _____ NPI#: _____

REFERRING PHYSICIAN PHONE#: _____

REFERRING PHYSICIAN FAX#: _____

REFERRING PHYSICIAN ADDRESS: _____

_____ 95819 ROUTINE EEG

_____ 95819 SLEEP DEPRIVED EEG

_____ 95953 AMBULATORY EEG

24 HR _____ 48HR _____ 72HR _____ 96HR _____

* TO SCHEDULE AN APPOINTMENT PLEASE CALL 212-305-1742
FAX# 212-305-5445

*** FORM MUST BE COMPLETED BY REFERRING PHYSICIAN**