Request of EEG Testing

Referring Physician Information

Name of contact person____

Phone________________________ Fax__________________________________

Referring M.D. ________________________________ **User #** _____________

Attending Physician __________________________ **User #** _____________

Patient Information

ICD9 and Diagnosis____

Patient Name ____

Date of Birth _________________________ Phone#______________________

Last four of Social Security # _________________

Insurance ________________________ PCP ____________________________

Authorization #_____________________

Test Requested

Routine EEG w/2 ch. ECG tracing _____

Sleep Deprived EEG w/2 ch. ECG tracing _____

Extended EEG w/ECG 41-60 MIN. ______ >61 MIN. ______

History:

Neurodiagnostics Laboratory
at Clovis Community Medical Center
2755 Herndon Ave. Clovis, CA 93611
Phone: (559) 324-4977 Fax: (559) 324-3742