

## VIDEO EEG REQUEST FORM

**IN PATIENT** (*Estimated Duration*)    **1-3 days**    **3 -5 days**    **5-7 days**    **7 days +**

**OUT PATIENT**    **24 hrs**    **48 hrs**    **72 hrs**

**EKG Interpretation**    **Yes**    **No**

Date: \_\_\_\_\_ Requested by: \_\_\_\_\_

(person filling out form)

**Request Status:**    **Emergency**    **Urgent**    **Rush**    **ASAP**    **Routine**

Ordering Dr.: \_\_\_\_\_ Referring Dr.: \_\_\_\_\_

Patient Name: \_\_\_\_\_ MRN: \_\_\_\_\_

Age & Gender \_\_\_\_\_ DOB: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Provider # \_\_\_\_\_ Tel # \_\_\_\_\_

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**R/O Non-Epileptic Events**    **Pre-Surg. Evaluation**    **Medication Adjustment**    **Other**

History: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Seizure Description: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Current Medications/Doses: \_\_\_\_\_

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**Dates of Previous Tests**

Video EEG: \_\_\_\_\_

EEG: \_\_\_\_\_

MRI: \_\_\_\_\_

SPECT: \_\_\_\_\_

CT: \_\_\_\_\_

PET: \_\_\_\_\_

**Please Submit Request with Recent Clinic Notes / Consultation Reports**

**Fax: 631 - 474 - 6762**