Phone - (317) 333-7390
Fax - (866) 859-7105

In Home Neurodiagnostics

Request for Long Term EEG monitoring

Patient Information:	
Name:	Address:
Date of Birth:	City:
Home Phone:	State:
Insurance Type:	Zip Code:

Please Fax Copy of Order, Scan of Insurance Card and PT Hx when Possible.

EEG Type: Please Circle

95951 - Ambulatory EEG, w/ Video

95819 - Routine EEG, Sleep Deprived

Other - _____

EEG Duration: Please Circle

24 Hours 48 Hours 72 Hours

96 Hours Other _____

Diagnosis Coding: Please Circle

F44.5	Conversion Disorder with Seizures
G40.009	Focal Non-Intractable Epilepsy and Recurrent Seizures
G40.019	Focal Intractable Epilepsy and Recurrent Seizures
G40.309	Generalized Non-Intractable Nonconvulsive Epilepsy
G40.319	Generalized Intractable Nonconvulsive Epilepsy
G40.919	Unspecified Intractable Epilepsy
G40.909	Unspecified Non-Intractable Epilepsy
R55	Syncope and Collapse
R56.1	Post Trumatic Seizures
R56.9	Other Convulsions or Spells

Other _____

Notes:

Physician's Signature:	**Date:**
X	X