Phone - (317) 739-3386
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 Traumatic Seizures |
| R56.9 | Other Convulsions or Spells |

Other _____

**Notes:**

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