



Quality Testing at Your Convenience

Patient Name		Date of Birth	
Address		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
City	State	Zip	
Phone (Home)	Phone (Cell)	Phone (Work)	
Patient Insurance	Subscriber ID	Group ID #	Insurance Phone #

Please Send Copy of Order, Scan of Insurance Card and PT Hx to: **FAX: 866-859-7105**

**\*\*\*Routine EEG must be ordered or completed prior to any Video EEG services\*\*\***

**Has Patient had Routine EEG: Yes No** If Yes, please include the report along with demographics and H&P  
(within past year) If No, we will provide one prior to Video EEG acquisition

Please choose from the following DX codes which are universally acceptable by all insurances for an Ambulatory LTM EEG

- F44.5 Conversion Disorder with Seizures
- G40.009 Focal Non-Intractable Epilepsy and Recurrent Seizures
- G40.019 Focal Intractable Epilepsy and Recurrent Seizures
- G40.209 Localization-related (focal)(partial) Symptomatic Epilepsy
- 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

OFFICE USE ONLY

Drive Time: \_\_\_\_\_  
 Call Log: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Scheduled: \_\_\_\_\_  
 Test Info: \_\_\_\_\_

<input type="checkbox"/> <b>Video EEG Duration</b> <input type="checkbox"/> 24 Hour <input type="checkbox"/> 96 Hour <input type="checkbox"/> 48 Hour <input type="checkbox"/> 120 Hour <input type="checkbox"/> 72 Hour      Custom _____	<input type="checkbox"/> <b>Routine EEG w/Activations</b> <input type="checkbox"/> HV <input type="checkbox"/> Photic <input type="checkbox"/> Sleep Deprivation <input type="checkbox"/> Other:  <input type="checkbox"/> All Above	<b>Contact Us:</b>  <b>Fax:</b> 866-859-7105  <b>Billing:</b> 317-739-3386  <b>Scheduling:</b> 317-804-9652
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**\*\*Activations with Routine EEG Only\*\***

All EEG setups and monitoring are performed and/or supervised by a Registered EEG Technologist certified by the American Board of Registered Electroencephalographic Technologists which will perform EEG monitoring services by cable/radio 16 channel or more telemetry.

Patient Notes:

**The referring physician who submits this order/verification form is hereby giving authorization to allow In Home Neurodiagnostics to perform an EEG on this patient. The referring physician has acknowledged the duration, monitoring and technologist requirement. Both the referring and interpreting physicians are aware of the EEG equipment capabilities.**

Referring Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician Email (optional): \_\_\_\_\_

Interpreting Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature above is referring physician or by an authorized representative of the referring physician)

Email or Fax results to: \_\_\_\_\_