In Home Neuro

Quality Testing at Your Convenience

Routine and/or Ambulatory EEG Order Form

Patient Name			Date of Birth
Address			Sex: ❑ Male ❑ 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**

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: _____

□ **With Video** □ **Without Video** *must select option for ambulatory study*

EEG Duration

☐ 24 Hour ☐ 96 Hour
☐ 48 Hour ☐ 120 Hour
☐ 72 Hour Custom_____

Activations: ☐HV ☐Photic

☐ **Routine EEG >1Hr**
☐ HV ☐ Photic
☐ Sleep Deprivation
☐ Other:

☐ All Above

Contact Us:

Fax: 866-859-7105

Billing: 317-333-7390

Scheduling: 317-617-0248

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

StudyNotes: 95813 Extended EEG monitoring> 1hr is used to help ensure a more comprehensive study and an increased likelihood of capturing sleep.

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:_____