NORTHERN NEUROLOGY SPECIALTIES

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BOARD CERTIFIED IN NEUROLOGY

VIDEO AMBULATORY EEG REFERRAL FORM

PATIENT NAME:_____DATE OF BIRTH:_____

ADDRESS:_____SEX: M◯F◯

CITY:_____STATE:_____ZIP:_____

PHONE(H):_____(W):_____SS#:_____

INSURANCE CARRIER_____

_____

REASONS:

- ☐ Clinical Seizures
- ☐ Convulsions
- ☐ Possible Seizures Episodes of Shaking
- ☐ Jerking
- ☐ Involuntary movements
- ☐ Tremors (where)_____
- ☐ Episodes of numbness
- ☐ Weakness (where)_____
- ☐ Episodes of Unexplained Loss of Consciousness
- ☐ Unresponsiveness
- ☐ Syncope
- ☐ Falls
- ☐ Cognitive Dysfunction
- ☐ Memory Lapses
- ☐ Confusion
- ☐ Staring
- ☐ Paroxysmal Dizziness
- ☐ Paroxysmal Speech Disturbance

_____(OTHER) _____

_____

REQUISITION

_____DIFFERENTIAL DIAGNOSIS___EVALUATE EPILEPSY/SEIZURE CLASSIFICATION

_____MONITOR INTERICTAL ACTIVITY_____OTHER:_____

_____ **LENGTH_____72 HRS_____48 HRS** **ROUTINE EEG_____**

____DOUBLE BANANA_____CORONAL TEMPORAL _____CORONAL PARASAGITTAL

_____

PHYSICIAN:_____ DATE:_____

SIGNATURE:_____NPI#_____

_____

FOR OFFICE USE TEST NUMBER_____TEST DATE_____ TECHNOLOGIST HOOK- UP_____TECHNOLOGIST DISCONNECT_____

NOTE: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK) WITH REFERRAL FORM.