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Ambulatory EEG Recordings
Diagnostic Testing Order Sheet

Patient Name:______ ________________ Phone#________________________
Address:______________________________ Alt. Phone #:______________
______ ____________________ DOB:__________ Sex: M/F ______
______________________________ Guardian name:__________________
(if pt is minor)
Insurance:______________________ Subscriber #____________ Group#______

Primary MD:__________________
SS#:__________________________________ Diagnosis:__________________

Testing for: Epilepsy/Seizure disorder____ Syncope__ Other__________

Sleep Disturbance___________ Differential Diagnosis_________

Test type : Overnight Sleep EEG_____

____Ambulatory EEG ______Ambulatory Video EEG ECG Monitoring: ____Yes ___No

Length of Test:

___24 hrs ____ 48 hrs ____ 72 hrs ____Longer* _____Until Event Occurs
(*please specify in days or hours)

Montage:
____Double Banana ____Coronal Temporal ____Coronal Parasagittal

Has the patient had a previous EEG? __________ If so, where and when?____________ *Current Meds/anticonvulsants:____
____

Ordering MD:______________ Fax results to phone #______________

Date Ordered:______________ Mail results to address:______________

MD signature:_______ _______ __________________________

Interpreting MD Preference:____________________