Ambulatory EEG Recordings
Diagnostic Testing Order Sheet

Patient Name: ____________________________________ Phone #:____

Address: ____ Alt. Phone #: _____________________________________

____ DOB: ________________________________ Sex: M / F

____ Parent or Guardian Name: __________________________
(if patient is a minor)

Insurance: _______________________________________ Subscriber #: ________________ Group #: ____________

Primary MD: _____________________________________

SS#: ____ Diagnosis: _______________________________________

Testing for: Epilepsy/Seizure Disorder _____ Syncope _____ Other ____

Sleep Disturbance _____ Differential diagnosis _____

Test Type:

_____ Ambulatory EEG *or* _____Ambulatory ***Video*** EEG *or* Overnight Sleep EEG _____

ECG Monitoring: _____ Yes _____ No

Length of Test:

_____ 24 hrs _____ 48 hrs _____ 72 hrs _____ Longer* _____ Until Event Occurs _____ Max Length (Days)
(*please specify in days or hours)

Has the patient had a previous EEG? Yes / No If "Yes", where and when? ______________________________________

*Current Meds/Anticonvulsants: ____

Special Seizure/Event Settings: ____

Ordering MD: _____________________________________ Ordering MD phone #: _____________________________

MD UPIN#: _______________________________________ Fax results to phone #: ____________________________

Date Ordered: ____________________________________ Mail result to address: ____________________________

MD Signature: ____

Interpreting MD Preference: ____

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