SYNERGY DIAGNOSTICS

AMBULATORY/ROUTINE EEG ORDER FORM

Fax: 832-218-6416 / Phone: 832-962-9121

Patient Name: _____ **DOB:** ____ /____ /_____ **Phone Number:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Insurance: _____ **ID#**_____ **Group#**_____

CLINICAL HISTORY

Diagnosis : _____

PROCEDURE ORDERED

All Procedures include Digital Seizure/Spike Detection Analysis (95957) and ECG (93268)

❑ Ambulatory EEG (95951) (95956)

_____ 24 hour _____ 48 hour _____ 72 hour _____ 96 hour _____ 120 hour

❑ Routine EEG with Video

_____ 41-60 minutes (95812) _____ 61 + minutes (95813)

❑ Nocturnal EEG Recording with Video (All night) (95827)

Physicians Name: _____

Physicians Signature: _____ Date: ____ / ____ / _____

NPI#: _____ Office Phone: _____ Office Fax: _____

Physician Statement: I certify that I am referring the above named patient for an Electroencephalogram (EEG), or video long Term EEG. This test is medically necessary in order to diagnose the patient. I understand that the diagnostic provider will not provide a diagnosis nor will they recommend treatment for this patient.

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