NEUROLOGIC GUARD
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Ambulatory EEG Referral Form

PLEASE FAX

1) Referral Form 2) EEG Screening QS 3) Facesheet 4) Previous Office Visit Note
5) Previous EEG Results (if applicable) 6) Copy of insurance card

Fax Number: 1-469-213-8448

Patient Information

Last Name_____ First Name_____ Middle Name_____

Social Security#_____ DOB_____

Street Address_____ City_____ State_____Zip Code_____

Insurance Information

Primary_____ ID#_____ Group#_____

Secondary_____ ID#_____ Group#_____

Ambulatory EEG Length

☐ 48hrs ☐ 72hrs ☐ 96hrs ☐ 120hrs

Previous EEG [Include results of previous study]

☐ Routine ☐ Routine ☐ None

Results of Previous EEG

☐ Normal ☐ Abnormal

Please Include the following with each Referral

- ☐ Referral Form Signed by Physician (Present Form)
- ☐ Ambulatory EEG Screening Questionnaire Signed by Physician & Patient
- ☐ Copy of Patient Insurance Card (Front & Back)
- ☐ Demo/Facesheet
- ☐ Previous Office Visit Notes (PMHx & Medication list)
- ☐ Previous EEG Testing Results (If Applicable)

Referring Condition ICD-10 Codes

Primary [Required] – Clinical notes must support study

- ☐ R40.4 Transient Alterations of Awareness
- ☐ G40.A09 Absence epileptic syndrome, not intractable, without status epilepticus
- ☐ G40.309 Generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus
- ☐ G40.209 Partial Seizures: Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures not intractable, without status epilepticus
- ☐ G40.909 Unspecified epilepsy: Epilepsy, unspecified, not intractable, without status epilepticus
- ☐ Other _____

Secondary ICD-10 Codes [Optional]

- ☐ R42 Dizziness & Giddiness
- ☐ R55 Syncope & Collapse
- ☐ R56.1 Post traumatic seizures
- ☐ R56.9 Other convulsions

Physician Information

Practice Name_____ Physician Name_____ NPI #_____

Address_____ City_____State____ Zip Code_____ Phone_____

☐ I would like a neurologist/epileptologist to read/interpret my studies

☐ I will read/interpret my own studies

*Transmission of all information will meet HIPPA compliance standards

Physician Signature_____ Date Signed_____

Patient Signature_____ Date Signed_____