Hartford HealthCare

Ayer Neuroscience Institute

EEG
(MOB Suite 815)
Phone: 860-972-3621 Fax: 860-545-5003

Electroencephalogram (EEG) Referral Form

Ordering Physician _____

Phone _____ Fax _____

Please Print Patient Information:

Name_____ DOB: _____Gender ❑ F ❑ M

Address _____ City _____ State _____ Zip _____

Phones: Home_____ Work_____ Cell_____

Emergency Contact _____Phone_____

Insurance: _____ | Secondary Insurance_____

ID# _____ | ID#_____

Worker's Compensation_____

Worker's Compensation Contact _____ Phone _____

Claim/Authorization# _____ Date of Incident_____

Prior Authorization Required? Y / N **Authorization Number:**_____

STUDY TO BE DONE:

❑Routine EEG ❑Sleep Deprived EEG ❑ Monitoring with video, greater than 1 hour

❑24 hour ambulatory EEG ❑48 hour ambulatory EEG ❑72 hour ambulatory EEG

Suspected Disorders (check all that apply)

❑Seizure disorder	❑Screening- neurological	❑Dementia	❑Alzheimer's disease
❑Suspected seizures	❑ADD	❑Syncope	❑Amnesia
❑Ongoing seizure activity	❑Aphasia	❑Psychiatric: behavior changes, psychosis	❑Ataxia
❑Altered mental status	❑Confusion	❑Headaches	❑Parkinson's disease
	❑Cognitive Impairments		❑Multiple sclerosis, NOS

ICD-10 code: _____

Additional clinical information:_____

_____

_____

_____

PLEASE FAX FORM TO: (860) 545-5003

_____ _____ _____

Physician Signature **Date** **Time**