EEG Order

This must be accompanied by a Referral Form.

Schedule with Humboldt Neurology (**Fax: 442-2362**) Testing Performed at St. Joseph Hospital

Patient Name: _____ **Patient DOB**:_____

Referral for: _____ **Routine EEG** (awake/drowsy) CPT: 95816
(check one)

_____ **Sleep Deprived EEG** (awake/drowsy/asleep) CPT: 95819
Patients aged 13-adult will be required to stay awake 24 hours prior to appointment time. Instructions regarding sleep for patients under the age of 13 will be discussed when scheduling.

_____ **Child under age 5.** We request all children under the age of 5 to be sleep deprived to assist in the cooperation of the patient and technical quality of the recording. The amount of deprivation will vary depending on the age and behavior of the child. Our office will discuss w/parent at time of scheduling.

ICD-10 code: ** Required EEG appointment cannot be scheduled without an appropriate code.**

1. **Code** _____ **Brief description**_____
2. **Code** _____ **Brief description**_____
3. **Code** _____ **Brief description**_____
4. **Code** _____ **Brief description**_____

Additional comments or instructions: _____

_____

Provider signature: _____ **Printed Name**:_____
(Include credential)

Supervising Physician (if referred by mid-level) _____

*Appt. date*_____ *Appt. time*_____
(Completed by Humboldt Neurology)

Revised 3-3-16