

Check One

Lincoln Medical Center
6 Blackstone Valley Place, Bldg. 7
Lincoln, RI 02865

East Greenwich Medical Center
1407 South County Trail,
East Greenwich, RI 02818 Bldg. 4, Ste. 430

ENT Center of RI, Warwick
55 Lambert Lind Hwy.
Warwick, RI 02886

Swansea Professional Center
1010 GAR Highway (Rte. 6)
Swansea, MA 02777



Ambulatory EEG Services

In RI: Phone: 401-541-9188 • Referral Fax: 401-541-9199 In MA: Phone: 508-646-4303 • Referral Fax: 508-646-4304
www.epochsc.com

PATIENT INFORMATION

Name: _____ DOB: _____ M/F: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell/Alt. Phone: _____
Emergency Contact: _____ Phone: _____
Primary Insurance: _____ Insurance #: _____

DIAGNOSIS/INDICATIONS

- | | | |
|---|--|---|
| <input type="checkbox"/> Abnormal EEG (794.02) | <input type="checkbox"/> Epilepsy, Generalized (345.1__) | <input type="checkbox"/> Seizure, NOS (780.39) |
| <input type="checkbox"/> Behavior Problems (312.9) | <input type="checkbox"/> Loss of Consciousness (780.09) | <input type="checkbox"/> Syncope/presyncope (780.2) |
| <input type="checkbox"/> Change in Mental Status (780.99) | <input type="checkbox"/> Migraine with Aura (346.0__) | <input type="checkbox"/> TIA (435.9) |
| <input type="checkbox"/> Encephalopathy (348.3__) | <input type="checkbox"/> Movement Disorder (333.90) | <input type="checkbox"/> Abnormal Involuntary Movements (781.0) |
| <input type="checkbox"/> Epilepsy, NOS (345.9__) | <input type="checkbox"/> Myoclonic Jerking (333.20) | <input type="checkbox"/> Visual Disturbance (368.9) |
| <input type="checkbox"/> Epilepsy, Partial (345.4__) | <input type="checkbox"/> Paresthesia (782.0) | <input type="checkbox"/> Other _____ |

CLINICAL OBJECTIVE

- | | |
|--|---|
| <input type="checkbox"/> Differential diagnosis | <input type="checkbox"/> Preoperative evaluation for epilepsy surgery |
| <input type="checkbox"/> Epileptic versus Non epileptic seizures | <input type="checkbox"/> Monitor interictal activity |
| <input type="checkbox"/> Identification of seizure type | |

TEST REQUISITION

Duration 24 hour 48 hour 72 hour Other _____
Video Yes No
EKG Yes No

Pertinent Clinical History: _____

Medications: _____

Previous EEG History: _____

REFERRING PHYSICIAN STATEMENT

- I certify that I am referring the above named patient to Epoch Sleep Center for long-term neurophysiological monitoring using the Epoch Sleep Center monitoring system.
- I certify to the best of my knowledge, this test and any interpretation is medically necessary in order to diagnose this patient.
- I understand that this test and any interpretation provided are intended only to supplement my diagnosis of this patient's condition.

PROVIDER INFORMATION

Referring Physician /NP/PA Name: _____

Phone: _____ Fax: _____

Primary Care Physician Name: _____

 **Physician /NP/PA Signature** _____ **Date**

FOR EPOCH SLEEP CENTER AND NEURO-DIAGNOSTIC SERVICES ONLY

Check if physical exam is listed in referring M.D.'s notes

History reviewed by _____ M.D. Date _____ / _____ / _____