THE QUEEN'S MEDICAL CENTER

Neurodiagnostic Laboratory
1301 Punchbowl St., Honolulu, HI 96813
Phone: (808) 691-4218
Fax: (808) 691-7025

DATE: _____

OUTPATIENT INFORMATION / REQUISITION

PRIOR AUTHORIZATION IS REQUIRED BEFORE TO SCHEDULING

PATIENT NAME: _____

DOB: _____ SEX: _____ APPOINTMENT DATE & TIME _____

INSURANCE & AUTHORIZATION (fax a copy): _____

WORKER'S COMP, AUTO ACCIDENT (ADJUSTER CONTACT INFO), DATE OF INJURY/MVA

_____

IF PATIENT IS UNABLE TO SCHEDULE AN APPOINTMENT, PLEASE LIST BEST CONTACT PERSON:

CONTACT PERSON'S NAME & RELATION: _____

PHONE NUMBER(s) HOME: _____ MOBILE: _____ OTHER: _____

ELECTROENCEPHALOGRAM:	**CPT CODE**	**EVOKED POTENTIAL**:	**CPT CODE**
_____ AWAKE & DROWSY	95816	_____ VISUAL	95930
_____ SLEEP DEPRIVED	95819	_____ AUDITORY	92653
_____ EEG 2 HRS	95818	_____	
TRANSCRANIAL DOPPLER		**UPPER EXTREMITY SSEP**	
_____ COMPLETE	93886	_____ MEDIAN	95925
		LOWER EXTREMITY SSEP	
_____ LIMITED	93888	_____ TIBIAL	95926

VIDEO ELECTROENCEPHALOGRAM:	**CPT CODES**	
_____ 24 HR MONITORING WITHOUT VIDEO	95708, 95719, 95700	These procedures must be approved by a neurologist with privileges to read prolonged video EEG
_____ 24 HR MONITORING W/VIDEO	95714, 95720, 95700	
NOTE: 48 HRS WITH VIDEO (95714 x2)	48 HRS WITHOUT VIDEO (95708 x2)	

DIAGNOSIS/ICD 9 CODE: _____

PRIMARY CARE PHYSICIAN (PCP): _____

REFERRING PHYSICIAN NAME, ADDRESS, AND PHONE NUMBER

_____

_____

_____

_____

REFERRING PHYSICIAN SIGNATURE

THE ABOVE TEST/PROCEDURE IS MEDICALLY NECESSARY