THE QUEEN'S MEDICAL CENTER

Neurodiagnostic Laboratory
Phone: (808) 691-3135
Fax: (808) 691-3347

OUTPATIENT INFORMATION / REQUISTION

PATIENT NAME: _____

DOB: _____ SEX: _____ APPOINTMENT DATE and TIME: _____

PHONE - HOME: _____ WORK: _____ CELL: _____

EMAIL ADDRESS: _____

INSURANCE (FAX A COPY): _____

AUTHORZATION NUMBER: _____

WORKERS' COMP, AUTO ACCIDENT (ADJUSTER CONTACT INFO), DATE OF INJURY/MVA:

_____

ELECTROENCEPHALOGRAM (EEG):

_____ ROUTINE EEG

_____ PUNCHBOWL _____ WEST O'AHU

_____ SLEEP DEPRIVED EEG

_____ PUNCHBOWL _____ WEST O'AHU

_____ EEG GREATER THEN 1 HOUR

____ 61 MINS ____ 2 HOURS ____ 4 HOURS

_____ AMBULATORY EEG MONITORING

_____ 24 HOURS W/ VIDEO*

_____ 24 HOURS W/OUT VIDEO*

EVOKED POTENTIAL:

_____ VISUAL

_____ AUDITORY

_____ UPPER EXTREMITY SSEP

_____ MEDIAN _____ ULNAR

_____ LOWER EXTREMITY SSEP

_____ TIBIAL

TRANSCRANIAL DOPPLER:

_____ COMPLETE

_____ TCD W/ EMBOLI

For inpatient video EEG monitoring in the epilepsy monitoring unit (EMU*), please contact the Epilepsy Program Coordinator at (808) 691-7300.

*These procedures must be recommended by a neurologist or approved by a Queen's epileptologist.

DIAGNOSIS / ICD 10 CODE: _____

PRIMARY CARE PHYSICIAN (PCP): _____

REFERRING PHYSICIAN:

_____ _____
NAME

_____ _____
ADDRESS

_____ _____
OFFICE PHONE NUMBER OFFICE FAX NUMBER

_____ _____
PHYSICIAN SIGNATURE DATE

THE ABOVE TEST/PROCEDURE IS MEDICALLY NECESSARY