



Sleep Disorders
Neuroscience

Group NPI # 1104458462
Individual ID # 1427091727
Tax ID # 832292471

Neuro Synchrony Center
1745 E Hwy 50, Suite B1 Clermont, FL 34711
Phone: (352) 404-8428
Email: info@neuro-synchrony.com
Please fax to (866) 984-4064

PHYSICIAN DIRECT REFERRAL FORM FOR EEG STUDY

| PATIENT INFORMATION | | |
|--|--|--------|
| Name: | Gender <input type="checkbox"/> M <input type="checkbox"/> F | DOB: |
| Home Address: | Phone: | |
| Insurance: | Policy Number: | |
| Emergency Contact: | Phone: | |
| SERVICE REQUESTED | | |
| <input type="checkbox"/> Neurology Consultation (99205) | <input type="checkbox"/> Continuous video EEG monitoring (95716) | |
| <input type="checkbox"/> Routine EEG 30-60 minutes (95816) | <input type="checkbox"/> Patient set up video EEG (95700) | |
| REASON FOR TESTING | | |
| | | |
| ICD 10 Code: | | |
| ADDITIONAL CLINICAL INFORMATION | | |
| | | |
| SPECIAL NEEDS | | |
| <input type="checkbox"/> Assistance in/out of bed | <input type="checkbox"/> Oxygen LPM _____ | |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Dementia | |
| <input type="checkbox"/> Needs interpreter _____ | <input type="checkbox"/> Aide required at home | |
| Please fax this form to (866) 984-4064 prior to scheduling the patient's EEG study and include: | | |
| <input type="checkbox"/> Written order for the EEG with appropriate indications <input type="checkbox"/> Patient demographics history and most recent physical <input type="checkbox"/> Seizure history and routine EEG report <input type="checkbox"/> Current list of medications and allergies <input type="checkbox"/> Copies of insurance or Medicare/Medicaid cards <input type="checkbox"/> Prior authorization number and copy of approval letter from insurance provider | | |
| Ordering Physician: | Specialty: | NPI: |
| Office Phone: | Office Fax: | Email: |
| Physician Signature: | Date: | |