

EEG Order



* = Required Field

*Patient First Name Patient Middle Name *Patient Last Name *Patient DOB *Patient Gender
M F
month/day/year - ex 01/02/2018
*Parent/Guardian First Name *Parent/Guardian Last Name *Parent/Guardian Mobile Number *Parent/Guardian Alternate Number
Enter a 10-digit Phone Number Enter a 10-digit Phone Number

***Ordering Provider Information:**

Please provide information for the licensed ordering provider. Medical students, list your authorizing physician as the referring provider.

*Ordering Provider NPI# *Ordering Provider First Name *Ordering Provider Last Name *Ordering Provider Office Phone Number
Enter a 10-digit Phone Number
*Ordering Provider Fax Number Ordering Provider Office Address City State Zip Code

***Reason For Exam** *(Check all that apply to the patient):*

- Change in Mental Status
- Head Injury
- Known Seizure Disorder
- Monitor Seizure Activity
- New Onset Seizures
- Staring Spells
- Other

***Patient Diagnosis:**

Preferred Location:

Medical Center West Campus Cypress Fairbanks Clear Lake Sugar Land The Woodlands

***Ordering Provider Signature:**

Name:

Date Signed: