Electroencephalography (EEG) and Evoked Potential Request Form

Phone: (866) 346-2362
Fax: (603) 676-4080

Please select the service requested: ☐ Test and consultation ☐ Test only

For Test only, please select service(s) requested:

EEG (Adult or Pediatric): ☐ Routine 90 min (sleep deprived) ☐ 24-hour Ambulatory EEG

Evoked Potential (Adult only): ☐ Visual Evoked Potential (VER) ☐ Brainstem Evoked Potential (BAER)

☐ Somatosensory Evoked Potential(s) (Check all that apply): ☐ Upper limb (PT) ☐ Lower limb

(SEP)

Diagnosis/Reason for test: ______________________________

For EEG and consult requests, specialist preferred/requested (optional): ______________________________

Urgency of appointment ☐ Routine ☐ Urgent Explain: ______________________________

Todays Date	**DOB**	☐ **Male** ☐ **Female**
Patient Name (Last, First)		**Middle Initial**
Address		
Home phone	**Cell phone**	**Work phone**
Mailing Address		
Guarantor Name	**Guarantor DOB**	
Language assistance needed: ☐ **Patient** ☐ **Parent/Guardian**	**Language**	
Primary Care Provider (if different from referring)	**Subscribers Name**	
Office Phone	**Office Fax**	
Referring Provider	**Office Phone**	
Contact Name	**Office Fax**	
Address		

For Neuro appointments in Manchester, Please use the Manchester Neurology Referral Form at **https://www.dartmouth-hitchcock.org/referrals/manchester_referrals.html**

Please visit or website for specialty provider office locations, direct phone/fax numbers at **dartmouth-hitchcock.org** or for pediatrics at **childrens.dartmouth-health.org**

Referring Provider Signature (REQUIRED): ______________________________

Please attach insurance, relevant office records and/or prior studies/images with this form.

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