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DAVID S. FILIPPI, MD

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EEG STUDY REQUEST

Referring Physician Name: _____

Phone: _____ **Fax:** _____

Patient Name: _____

Exam Requested:

☐ Electroencephalogram (EEG), awake and asleep (95819)

Sleep Deprivation Request & Authorization:

☐ I am requesting a sleep-deprived study and have informed the patient that he or she **must** therefore have someone else drive him or her to and from the lab. *(Please note: Sleep-deprived studies should **not** be routinely ordered.)*

Symptom, Condition, or Suspected Condition To Be Tested:

☐ Epilepsy (345.90)
☐ Syncope (780.2)
☐ Febrile Convulsions (780.31)
☐ Other Convulsions (780.39)
☐ Migraine (346.90)
☐ Altered Mental Status (780.02)
☐ Dementia (290.0)
☐ Memory Loss (780.93)

Requires special authorization:

☐ Other *(**must** specify permitted ICD-9 code)*:

Other notes or specifications: _____

_____

_____

Please fax this completed form with your patient's insurance and demographic information to (805) 547-2228.