Kootenai Health Neurodiagnostic Department Referral Form

Instructions: Please email this referral form with a current H&P and a demographic page to Neurodiagnostics@kh.org or **fax** us at **208-625-4201**. Once we have received all the patient information we will contact the patient directly to schedule. If you need to schedule directly with us, or have questions about additional testing we offer, please call us at 208-625-4521.

Patient name: _____ DOB: _____ Age: _____

Contact phone: _____ Alternate phone: _____

Name of person(s) and phone number(s) to contact if other than patient or if patient is a minor:

_____

_____

Patient Insurance provider: _____ Prior Auth. #_____

Referring/Ordering Provider: _____

Ordering Provider's Signature & date: _____

Procedure Requested (check appropriate study):

☐ **95819 Video EEG, Awake & Asleep; up to 40min. (i.e. seizures, epilepsy, syncope, etc.)**

☐ **95816 Video EEG, Awake & Drowsy; up to 40min. (i.e. CVA, SDH, dementia, etc.)**

☐ **95812 Video EEG, extended 41-60 min.**

☐ **95813 Video EEG, extended monitoring; greater than 1 hour.**

☐ **95710 Ambulatory EEG, unattended monitoring w/o video**

*****Record for _____ days (please fill in the number of days needed)**

☐ **95930 VEP (Visual Evoked Potential)**

☐ **95925 SSEP, upper extremities (Somatosensory Evoked Potential)**

☐ **92587 ABR screening, newborn hearing screen under 6mo. old.**

ICD-1- code and Diagnosis description: _____

Send copies of Interpretation to: _____