Dartmouth-Hitchcock

Dartmouth-Hitchcock CHILDREN'S HOSPITAL AT DARTMOUTH

Electroencephalography (EEG) and Evoked Potential Request Form

Please visit our website for specialty provider office locations, direct phone fax numbers at www.DHMC.org or for pediatrics at www.chadkids.org

Lebanon: 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 (SPT)

☐ Lower limb (SEP)

Diagnosis/Reason for test: _____

For EEG & Consult requests, specialist preferred/requested (optional): _____

Urgency of Appointment: ☐ Routine ☐ Urgent Explain: _____

For Neurology appointments in Manchester, please use the Manchester Neurology Referral Form at http://med.dartmouth-hitchcock.org/referrals/manchester_referrals.html

Please complete patient information below, or attach patient demographic information before faxing.

Today's date: _____ DOB: _____ ☐ Male ☐ Female

Patient's Name: Last _____ First _____ MI _____

Address: _____

Home phone: _____ Cell: _____ Work: _____

Guarantor Name: _____ **Guarantor DOB:** _____

Language assistance needed: ☐ Patient ☐ Parent/Guardian Specify language: _____

Primary Care Provider (if different from referring): _____

Office Phone: _____ Office Fax: _____

Referring Provider: _____ Office Phone: _____

Contact Name: _____ Office Fax: _____

Address: _____

Referring Provider Signature (REQUIRED): _____

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