National Sleep Solutions Inc.
Sleep Specialist

FAX TO: 1-888-884-9493

Patient's Name: _____ DOB_____

Phone Number:_____

Health Insurance Member ID_____

URGENT ( ) YES ( ) NO

PLEASE INFORM US OF APPOINTMENT DATE AND TIME ( ) YES ( ) NO

PLEASE INCLUDE, CLINICAL NOTES, COPY OF INSURANCE CARD IF POSSIBLE.
(To be completed fully and legibly by referring physician)

INDICATE IF PATIENT NEEDS TO BE SLEEP DEPRIVED
(For more information visit www.nationalsleepsolutions.com)

REASON FOR EEG (CHECK AS MANY AS APPLY)

TO DETERMINE:

- ❑ IF EVENT(S) ARE SEIZURES *
- ❑ SEIZURE TYPE *
- ❑ EPILEPSY SYNDROME
- ❑ SUBCLINICAL SEIZURES *
- ❑ NON-CONVULSIVE STATUS *
- ❑ NEW SEIZURE TYPE *

TO EVALUATE:

- ❑ SEIZURE CONTROL FOLLOW-UP
- ❑ CHANGE IN MEDICATION
- ❑ RECURRENCE OR INCREASE IN SEIZUR

OTHER:

- ❑ REPEAT EEG FOR SLEEP
- ❑ TO CAPTURE AN EVENT *
- ❑ DECREASED LOC – CAUSE UNDETERMINED
- ❑ ENCEPHALOPATHIC
- ❑ OTHER please indicate *

*** BRIEF DESCRIPTION OF SEIZURE(S)/EVENT(S) IN QUESTION:**

_____

_____

AUTISM/AUTISTIC SPECTRUM DISORDER: N / Y Additional information: _____

CURRENT MEDICATION(S): _____

ARE YOU LOOKING FOR ANYTHING SPECIFIC: ▫ NO ▫ YES IF YES, SPECIFY:_____

ANY PROCEDURE(S) CONTRAINDICATED: ▫NO ▫ YESIF YES, SPECIFY:_____

PREVIOUS EEGS (DATE): _____ WHERE PERFORMED: _____

SEDATION REQUIRED: ○ NO ○ YES (all sedation patients must be send to hospital).

ALTERNATE SEDATION: ○ NO ○ YES (Prescription and administration must be arranged by the referring physician.)

I have discussed / received consent from the patient/parent for this procedure.

SIGNATURE OF REFERRING PHYSICIAN: _____ M.D.

MSP Billing #: _____

SEND REPORTS TO: _____

Revised Jul 2019