CHILDREN'S HEALTH



NEUROPHYSIOLOGY REQUEST Electroencephalogram (EEG) / Evoked

Patient Name:		
DOB:		

Complete and fax this order to the desired location. Include order form, patient demographics and last clinic

PHYO CMC38380-009NS Rev. 1	Potentials 1/2023 Electromyography / Nerve Conduction Study			
Location Requested: (required)	☐ Children's Medical Center Dallas	Children's Medical Center Pla 7601 Preston Rd., Plano, Tex Phone (469) 303-2740 Fax (469) 303-0671 or neurophysiologyplano.fax@c	xas 75024	
Diagnoses Code(s): (required)*	ICD10 codes:			
Study Requested: (required)*	 □ Electroencephalogram - EEG 41-60 minut □ Ambulatory EEG without Video: Please indice may require authorization, and clinical information r □ Visual Evoked Potential (VEP) □ Brainstem Auditory Evoked Potential (BAE □ Somatosensory Evoked Potential (SSEP) 	eate number of hours: equired. EP) Upper extremities	8 hours ☐ 72 hours	
	☐ Somatosensory Evoked Potential (SSEP) ☐ Electromyography / Nerve Conduction students of interest and any focal neurons.	dies (EMG / NCV) must include clinic	al information.	
Reason for study:	□ Seizure or suspected seizure□ Other Neurologic disorder (specify):			
□ I have discussed the indications for the procedure with the patient's parent(s) or legal guardian.				
		o □ dds □ rda □ pa Credentials		
Referring Provider Printed Name:		Date: <i>(required)*</i> _	_ Time:	
Office contact (name):				
Office phone:				
Office fax:				
This information is nec	essary for results follow up. Thank you.			