Neurology Request Form Fax back to ***407-365-3034*** With Patient's Recent History and Physical	Patients Age 2+ EIN: 11-3812755 NPI: 1700078979 NPI (Consults): 1427091727

☐ Falcon Oviedo Location **☐Falcon Metrowest Location** **☐ Patient Choice**

Patient Name:_______________________________________DOB:_______________________
Address:____
Home Phone: __________________________ Work/ Mobile Phone: ________________________
Insurance: _____________________________ Member ID: ______________________________

Patient Diagnosis: ______________________**DX Code:** __________

Any significant medical history? ☐ Yes ☐ No

If Yes, please specify_______________________________

Symptoms (Check all that apply):
☐ **Syncope**
☐ **Suspicion of seizures**
☐ **Suspicion of pseudo-seizures**
☐ **Frequent seizures despite the use of anti-seizure medications**
☐ **Episodes of confusion**
☐ **Dizziness / Vertigo**
☐ **Short-term memory problem**

Procedures Requested (Please check appropriate boxes):
☐ Neurologist Consultation
☐EEG Extended Monitoring; greater than 1 hour (CPT: 95813)
☐ EEG Including recording awake & drowsy; 20-40 minutes (CPT: 95816)
☐ EEG Including recording awake & asleep; 20-40 minutes (CPT: 95819)
☐ Monitoring for localization of cerebral seizure focus by cable or radio 16+ channels; Combined EEG recording & interpretations (each 24 hours) Indicate 24, 48, 72 hours____ (CPT: 95951)
☐Monitoring for localization of cerebral seizure focus by cable or radio 16+ channels; Combined EEG recording and interpretations without video (each 24 hours) attended by technologist. Indicate 24, 48, 72 hours _____ (CPT: 95956)

EEG AMBULATORY OPTIONS AVAILABLE

FOLLOWING CONDITIONS ARE NOT IN OUR SPECIALTY:

- **Multiple Sclerosis (MS)**
- **Neuromuscular**
- **Stroke**
- **Movement Disorder**
- **Accident Cases**
- **Pain Management**

Physicians Name_______________________ NPI #: _______________ EIN#: ________________
Signature: ____
Specialty: ☐ Psychiatrist ☐ Neurologist ☐ Family Practice ☐ Internal Medicine
☐Other (Please specify): ____________________________________
Address: ____Email: ________________________________
City: ____________________ State: _____ Zip: _______ Contact Person: _________________________
Phone: ___________________________________ Fax: ___________________________

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