

639 Granite Street, Suite 108, Braintree, MA 02184
For Assistance Call: (781) 848-9111 or (877) 566-9311
Please Fax To: (781) 848-3069 or (877) 307-8444



Billing

Patient Name: _____ Date Of Birth _____
Address: _____ Sex: Male _____ Female _____
Phone: (H) _____
(W) _____
Patient Insurance Carrier: _____ SS # _____ - _____ - _____

Epilepsy Database

Primary Diagnosis: _____ Secondary Diagnosis: _____
Etiology: _____

Test Requisition

Objective of Test:

_____ Differential Diagnosis _____ Evaluate Epilepsy / Seizure Classification
_____ Monitor Interictal Activity _____ Other: _____

Recommended Length of Monitoring: Until event occurs (up to _____ days) _____ 72 hours _____ 48 hours _____ 24 hours

ECG Monitoring: _____ Yes _____ No Video: _____ Yes _____ No

Montage Choice (see over): Double Banana Coronal Temporal Coronal Parasagittal
In the event that our registered EEG technologist determines that additional days of monitoring are required to meet your objectives, do you authorize another day of testing? _____ Yes _____ No

Clinical Background

Medications (Please indicate dosage if readily available):

_____ Carbamazepine _____ Clonazepam _____ Gabapentin _____ Lamotrigine _____ Levetiracetam _____ Oxcarbazepine
_____ Phenobarbital _____ Phenytoin _____ Primidone _____ Tiagabine _____ Topiramate _____ Valproic Acid
_____ Zonisamide

Previous EEG History: _____ Routine EEG _____ Ambulatory EEG _____ Sleep Deprived _____ Inpatient Monitoring _____ Other
Results: _____ Within Normal Limits _____ Abnormal _____ Slowing

Reader Preference: _____

Referring Physician Statement:

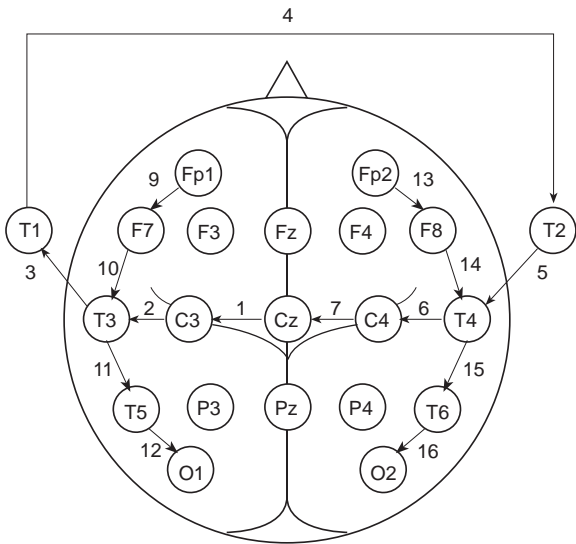
- I certify that I am referring the above named patient to SleepMed for long-term neurophysiological monitoring using the DigiTrace® Home Monitoring System.
- I certify to the best of my knowledge, this test and any interpretation is medically necessary in order to diagnose this patient.
- I understand that this test and any interpretation provided are intended only to supplement my diagnosis of this patient's condition. I recognize that SleepMed/DigiTrace will not provide a diagnosis of this patient nor will SleepMed/DigiTrace recommend any therapeutic measures for this patient.

Physician Signature _____ Phone # _____
Name (Please Print) _____ Zip Code _____
Date _____ Email Address _____

For Office Use	Test Number: _____	Test Location: _____
	Test Date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Registered Technologist: _____

Note: Please fax copy of insurance card (front & back) with Referral Form.

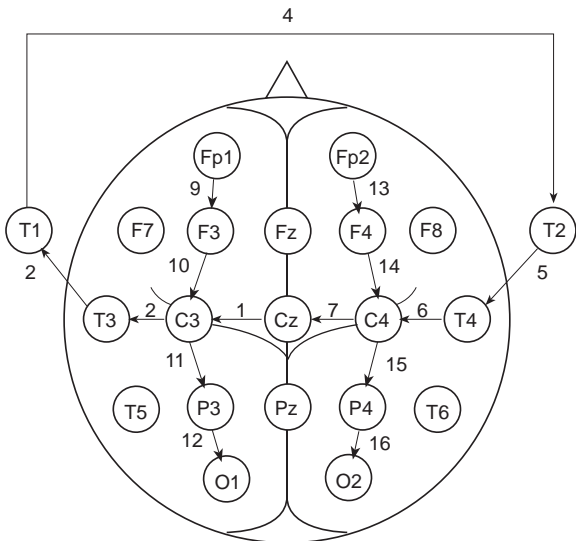
DigiTrace® Montage Selection



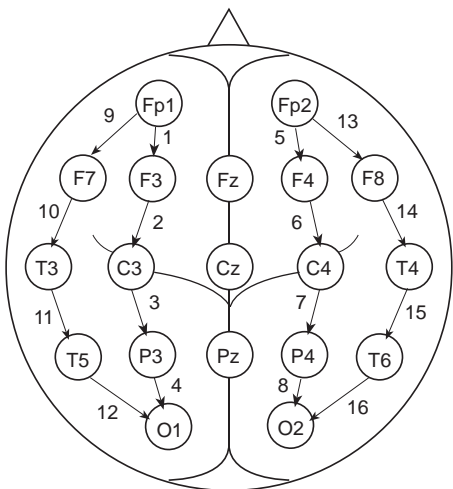
To select a montage, please check the appropriate box.



Coronal Temporal



Coronal Parasagittal



16 Channel Anterior to Posterior Arrays ("Double Banana")