



## NEURODIAGNOSTIC TESTING ORDER FORM

To schedule appointment complete form and fax with copy of patient insurance card to 770.832.9529  
or call: 770.832.2775, ext. 14

Patient Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Cell / Work Phone: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ Insurance Plan: \_\_\_\_\_

Physician to see: \_\_\_\_\_ **Reginald V. Hall, MD** \_\_\_\_\_ **Richard J. Mikilitus, Jr., MD** \_\_\_\_\_ **Fariba Farhidvash, MD**

**For:**

**Neurodiagnostic Test (s) requested:**

**We pre-certify all procedures prior to testing**

- |                                                     |                                                   |
|-----------------------------------------------------|---------------------------------------------------|
| _____ Electroencephalogram 95819                    | _____ EMG/NCV                                     |
| _____ Ambulatory 24 hour Electroencephalogram 95813 | _____ Bilateral upper extremity                   |
| _____ Somatosensory Evoked Potentials               | _____ Right upper extremity                       |
| _____ Lower extremities 95926                       | _____ Left upper extremity                        |
| _____ Upper Extremities 95925                       | _____ Bilateral lower extremity                   |
| _____ Brainstem Auditory Evoked Potentials 92585    | _____ Right lower extremity                       |
| _____ Visual Evoked Responses 95930                 | _____ Left lower extremity                        |
|                                                     | <b>Other:</b> _____ Lumbar Puncture               |
|                                                     | _____ Carotid Ultrasound (Carrollton Office Only) |

**Diagnosis:**

- |                                                          |                                           |
|----------------------------------------------------------|-------------------------------------------|
| _____ Partial Epilepsy with Intractability 345.51        | _____ Sensorineural Hearing Loss 389.1    |
| _____ Partial Epilepsy without Intractability 345        | _____ Amaurosis Fugax 362.34              |
| _____ Generalized Epilepsy with Intractability 345.11    | _____ Toxic Encephalopathy 349.82         |
| _____ Generalized Epilepsy without Intractability 345.10 | _____ Degenerative Dementia 331.2         |
| _____ Syncope 780.2                                      | _____ Alzheimer 331.0                     |
| _____ Numbness 782.0                                     | _____ Cervical Radiculopathy 953.0        |
| _____ Transient Visual Loss 368.12                       | _____ Lumbar Radiculopathy 953.2          |
| _____ Multiple Sclerosis 340                             | _____ Carpal Tunnel Syndrome 354          |
| _____ Vertigo-Central 386.2                              | _____ Ulnar Nerve Lesion 354.2            |
| _____ Vertigo-Peripheral 386.19                          | _____ Idiopathic Polyneuropathy           |
| _____ Occlusion of Cerebral Arteries 434.00 – 434.91     | _____ Gait 781.2                          |
| _____ Aphasia 784.3                                      | _____ Disturbance of Skin Sensation 782.0 |

**Other:** \_\_\_\_\_

I (referring physician) authorize the above tests to be completed and interpreted for the purpose of evaluating the above listed complaints and diagnoses.

<b>Print Referring Physician Name</b>	<b>Signature</b>	<b>Office Phone</b>	<b>Date</b>
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