YALE-NEW HAVEN HOSPITAL

EEG REFERRAL FORM

Office: 203.688.2495 Fax: 203.688.3109

PATIENT INFORMATION

PATIENT NAME	YALE MRN	DOB
ADDRESS	CITY, STATE, ZIP	
HOME PHONE	WORK PHONE	
EMAIL ADDRESS	FAX NUMBER	CELL PHONE

REFERRING PROVIDER INFORMATION

REFERRING PROVIDER	SPECIALTY
STREET ADDRESS	CITY, STATE, ZIP
PHONE NUMBER	FAX NUMBER

INSURANCE INFORMATION (PLEASE FAX AN ENLARGED COPY OF THE FRONT AND BACK OF THE INSURANCE CARDS – THANK YOU)

Primary Insurance	POLICY NUMBER
PHONE NUMBER	GROUP NUMBER

Test

☐ Routine EEG ☐ Sleep Deprived EEG (early morning appointments at 8 am)

☐ Portable EEG (patient must be hospitalized in a unit)

INDICATIONS (Please check/list identified symptoms of concern – REQUIRED TO SCHEDULE EXAM)

❑ Altered mental state ❑ Transient altered mental state ❑ Encephalopathy ❑ Convulsion

❑ Seizure ❑ Febrile convulsion ❑ Neonatal seizure ❑ Absence ❑ Epilepsy ❑ Amnesia

❑ Prior abnormal EEG ❑ Myoclonus / abnormal movements ❑ Apnea episodes ❑ Anoxic brain injury

❑ Subarachnoid hemorrhage ❑ Intracranial hemorrhage

Other reason _____

Medication List

Antiepileptic Drugs: _____

Sedatives: _____

Anxiety meds: _____

Other meds: _____

Other Comments:

_____

PRINTED PROVIDER NAME: _____

Signature of Ordering Provider: **Date:**

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