MY HOSPITAL
Hilo Medical Center
MY COMMUNITY

ELECTROENCEPHALOGRAM (EEG)

RESPIRATORY THERAPY PHONE: 932-3290 FAX: 932--3499
OUT-PATIENT INFORMATION / REQUISITION

PATIENT NAME: _____
(LAST, FIRST, MIDDLE INITIAL)

ADDRESS: _____ CITY: _____ STATE: _____

ZIPCODE: _____ PHONE: _____ BIRTHDATE: _____

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____

SECONDARY INSURANCE: _____

ADDRESS: _____

NAME OF SUBSCRIBER: _____

EMPLOYER: _____

DATE OF INJURY: _____ WORKER COMP? ☐ YES ☐ NO MVA? ☐ YES ☐ NO

POLICY OR CLAIM #: _____

ADJUSTER'S NAME: _____

PRE-APPROVAL ☐ YES ☐ PENDING PRE-APPROVAL BY: _____

DIAGNOSIS: _____ ICD-9 & ICD-10 CODE _____

ORDERING MD (PRINT) _____ (SIGNATURE) _____

DATE / TIME: _____ PRIMARY CARE PHYSICIAN: _____

AUTHORIZATION OR REFERRAL #: _____ (PLEASE FAX AUTHORIZATION / REFERAL WITH REQUISITION)

NO PRIOR AUTHORIZATION REQUIRED:_____

ELECTROENCEPHALOGRAPHY	CPT CODE
☐ EEG AWAKE AND DROWSY	95816
☐ EEG AWAKE AND SLEEPY	95819
☐ EEG EXTENDED UP TO HOUR	95812
☐ EEG EXTENDED MORE THAN HOUR	95813
☐ EEG IN COMA OR ASLEEP ONLY	95822

ENTRY DATE _____

PERSON GIVING INFO _____

UPDATE: _____

PERSON GIVING UPDATE: _____

SCHEDULING INFORMATION

APPOINTMENT DATE: _____

APPOINTMENT TIME: _____

ARRIVAL TIME: _____