Patient Name: _____ DOB: _____

Primary Care Physician: _____ Primary Ins.: _____

Ordering Clinician: _____ Ins #: _____

Diagnosis / Signs & Symptoms: _____ Secondary Ins.: _____

_____ Ins #: _____

Comments: _____ Pre−Cert #: _____

Chief Complaint: _____ Pre−approval: _____

Precautions / Allergies: _____ Appointment Date: _____

_____ Appointment Time: _____

Physicians / ARNP / PA Signature Required: _____ **Date/Time:** _____

Please *CHECK* item below.

* Electroencephlogram (EEG)		Time	Ambulatory (Home) EEG		Time
Routine EEG	❑	Approx. 60 min.	24 hour Ambulatory EEG with video	❑	Approx. 24 hrs.
* Sleep EEG	❑	Approx. 90 min.	48 hour Ambulatory EEG with video	❑	Approx. 48 hrs.
*** Neonatal EEG	❑	Approx. 180 min.	72 hour Ambulatory EEG with video	❑	Approx. 72 hrs.
Other (please specify)	❑		Other (please specify)	❑	

Video EEG (Long Term Monitoring)		Time	Evoked Potentials		Time
4 hour video EEG	❑	Approx. 4 hrs.	BAER (Brainstem EP)	❑	Approx. 60 min.
8 hour video EEG	❑	Approx. 8 hrs.	VEP (Visual EP)	❑	Approx. 60 min.
24 hour video EEG	❑	Approx. 24 hrs.	SSEP Upper (Median)	❑	Approx. 60 min.
48 hour video EEG	❑	Approx. 48 hrs.	SSEP Lower (Post Tib)	❑	Approx. 60 min.
72 hour video EEG	❑	Approx. 72 hrs.			
Other (please specify)	❑				

Polysomnogram (PSG): For Sleep Specialist Use Only (Oxygen therapy to be administered per established guidelines)		Time			Time
PSG − Diagnostic	❑	Approx. 10 hrs.	PSG − Diagnostic Daytime	❑	Approx. 10 hrs.
**PSG −CPAP Titration	❑	Approx. 10 hrs.	**PSG − CPAP Titration, Daytime	❑	Approx. 10 hrs.
**PSG − Split Night	❑	Approx. 10 hrs.	PSG − Diagnostic W/ MSLT	❑	Approx. 18 hrs.
**PSG − VPAP Adapt	❑	Approx. 10 hrs.	MWT	❑	Approx. 10 hrs.
PSG − Diagnostic W/Seizure Montage	❑	Approx. 10 hrs.	Home Sleep Testing (HST)	❑	Approx. 30 min.
Other (please Specify)	❑		Sleep Lab Follow−Up	❑	Approx. 15−40 minutes
			Sleep lab follow up, Level I (Simple)	❑	
			Sleep lab follow up, Level II (Intermediate)	❑	
			Sleep lab follow up, Level III (Complex)	❑	

PSG Direct Referral: To order use: Next Gen or Form 6171−30MR.pdf. "Guidelines for Obstructive Sleep Apnea, (OSA) Evaluation", which can be found in the WDH Forms Library on the WDH Portal.

***Sleep EEG's:** Require sleep deprivation. Children may sleep from 12am − 4am. Adolescents and adults are required to stay awake from midnight until the time of their scheduled test, unless otherwise directed by their physician.
***Neonates are tested during the infant's naptime.

Sleep Follow−Up: Patients are asked to bring their CPAP masks and CPAP machines to their appointment.

Physician Office: Please fax this to the WDH Neurosciences Dept @ 603.740.3310 and Scheduling @ 603.740.2398.

Patient Steps:
1) Call WDH Registration Dept. 603.740.2493 to pre−register.
2) You must bring this form to the hospital the day of your appointment.
3) Your insurance card must be presented at the time of your registration.
4) Questions or comments, call Neurology @ 603.740.2125 or Sleep Lab @ 603.740.6598.

Wentworth−Douglass Hospital
NEUROSCIENCES DEPARTMENT
REQUEST FOR OUTPATIENT NEUROLOGY AND SLEEP DISORDER TESTING

OD0020

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