



Request for Clinical Services Form

Name: _____ Gender: _____ Date of Birth: _____ SSN: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Patient Email Address: _____

Additional Contact: _____ Phone: _____

Insurance (please attach copy of patient's insurance card):

Primary: _____ ID #: _____ Group #: _____

Secondary: _____ ID #: _____ Group #: _____

REQUESTED SERVICES

☐ Routine EEG

☐ Long-Term AEEG _____ with video _____ without video _____ # days/hours

Check All Boxes That Apply

☐ AEEG order with Technical Study ONLY

☐ AEEG order with Technical Study & Professional Report

☐ Routine EEG with Technical Study ONLY

☐ Routine EEG with Technical Study & Professional Report

☐ Move forward with Long-Term AEEG if routine EEG Impression is "a normal routine EEG in the awake stat"

Diagnosis: _____

Current Medications: _____

Ordering Physician: _____

Physician Signature: _____ Date: _____

Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Please send a copy of the patient's insurance card, facesheet, physician notes, and list of medications with the referral form.

This referral constitutes an assignment of billing rights of the technical component by the practice/facility/physician for the services ordered and performed by Neurolinks, LLC.