

# EEG Scheduling Form

## Patient Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone (circle preferred): \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Primary Insurance: \_\_\_\_\_ Primary Insurance ID#: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Secondary Insurance ID#: \_\_\_\_\_  
Parent(s)/Legal Guardian(s): \_\_\_\_\_

## Ordering Clinic Information

Ordering Clinic Contact Name: \_\_\_\_\_  
Contact Number: \_\_\_\_\_  
Ordering Physician: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_

History of Symptoms: \_\_\_\_\_

Medications: \_\_\_\_\_

Comments: \_\_\_\_\_

Type of EEG:  Routine  Long Term (24 hours plus)

Provider Signature

Date

Time

**Please fax this completed EEG order form to the Boys Town EEG Lab at (531) 355-6089.  
Our technologist will contact the patient or patient's family to give testing instructions  
and schedule testing. Scheduling is done 8:00 a.m. - 5:00 p.m.**

14000 Boys Town Hospital Rd , Boys Town, NE 68010

Phone: (531) 355-6175 Fax: (531)-355-6089

boystownhospital.org

Last Updated: 3/2018

