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

Form No. 495 Last Updated: 3/2018

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