

Boys Town National Research Hospital 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)

Physician Signature

Date/Time

Please fax this completed EEG order form to the Boys Town EEG Lab at 402-778-6089.

Our technologist will contact the patient or patient's family to give testing instructions and schedule testing.

Scheduling is done 8 a.m. – 5 p.m.



14000 Boys Town Hospital Road • Boys Town, NE 68010
Phone: 402-778-6175 • Fax: 402-778-6089
boystownhospital.org

