Physician's Prescription & Statement of Medical Necessity for Ambulatory EEG Testing

Digitrace By SleepMed

Locations:
BRAINTREE * PEABODY * LEOMINSTER * PROVIDENCE, RI
Please fax completed form to: 781-848-3069 or 877-566-8444

PATIENT: _____ **SOC. SEC.#:** _____ **DOB :** _____ ☐ **M** ☐ **F**

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____

INSURANCE: _____ **ID#:** _____ **SUBSCRIBER:** _____

2ND INSURANCE: _____ **ID#:** _____ **SUBSCRIBER:** _____

(PLEASE PROVIDE A COPY OF THE PATIENTS H&P, OFFICE NOTES OR CLINICAL EEG HISTORY DOCUMENTATION)

CLINICAL SYMPTOMS

Date of onset of symptoms: _____

- ☐ G40.A01 Absence with status epilepticus
- ☐ G40. A09 Absence w/o status epilepticus
- ☐ G40.309 Generalized w/o status epilepticus
- ☐ G40.401 Other generalized with status epilepticus
- ☐ G40.409 Other generalized w/o status epilepticus
- ☐ G40.201 Focal epilepsy with status epilepticus
- ☐ G40.209 Focal epilepsy w/CPS w/o status epilepticus
- ☐ G40.211 Focal epilepsy w/CPS, intractable, w/ status epilepticus
- ☐ G40.219 Focal epilepsy w/CPS, intractable, w/o status epilepticus
- ☐ G40.901 Epilepsy, not intractable, with status epilepticus
- ☐ G40.909 Epilepsy, not intractable, w/o status epilepticus
- ☐ R56.9 Unspecified convulsions
- ☐ Other _____

PRELIMINARY DIAGNOSIS: _____
SECONDARY DIAGNOSIS: _____

TEST OBJECTIVE: ☐ **Differential Diagnosis** ☐ **Evaluate Epilepsy/Seizure Classification** ☐ **Monitor Interracial Activity** ☐ **Other** _____

PREVIOUS EEG HISTORY
Date of last routine EEG: _____ Results: ☐ Within Normal Limits ☐ Abnormal (Specify): _____

REQUESTED SERVICE/CPT CODE	**LENGTH OF MONITORING**	
☐ **Video EEG 95951**	☐ **72 Hours (3 Days)**	☐ **Until Event Occurs**
☐ **Non Video EEG 95953**	☐ **48 Hours (2 Days)**	**up to _____ days**
☐ **With EKG 93040/93041**	☐ **24 Hours (1 Day)**	

Reader Preference: **Dr. Andrew James Cole**

Referring Physician Statement:
- I certify that I am referring the above named patient to SleepMed/Digitrace for long-term neurophysiological monitoring using the DigiTrace Home Monitoring System.
- I certify to the best of my knowledge that this test and any interpretation is medically necessary in order to diagnose this patient.
- I understand that this test and any interpretation provided are intended only to supplement my diagnosis of this patient's condition. I recognize that SleepMed/DigiTrace will not provide a diagnosis of this patient nor will SleepMed/DigiTrace recommend any therapeutic measures for this patient.

REFERRING PHYSICIAN SIGNATURE: _____ **DATE:** _____

REFERRING PHYSICIAN (please print): _____ **NPI# :** _____

ADDRESS: _____ **TOWN :** _____ **STATE :** _____ **ZIP :** _____

PHONE: _____ **FAX:** _____

FORM COMPLETED BY: _____ **TITLE (NURSE, REFERRAL COORDINATOR, ETC):** _____