Outpatient EEG Referral Form

UCSF Health

Thank you for choosing to refer your patient to UCSF for an outpatient **Routine EEG** or an **Ambulatory EEG with video**.

To start the referral process, please:

- Complete this form and send to the EEG lab – **fax: (415) 353-8578 or email: EEGlab@ucsf.edu**
- Send a copy of the patient's insurance card (both sides) and HMO authorization if required.
- For help referring a patient, call (415) 353-1986.

TO: UCSF NEURODIAGNOSTIC SERVICES

Date: _____ No. of pages: _____ From: _____

Fax: _____ Phone: _____

TEST

☐ **Routine EEG**
Sleep Deprivation: ☐ Yes ☐ No
Prolonged study: ☐ 1 hr ☐ 2 hr
Special instructions _____

☐ **Ambulatory EEG with video**
☐ 24 Hours ☐ 48 Hours
Special instructions _____
_____

TEST LOCATION

☐ **Adult**
UCSF Medical Center
400 Parnassus Ave, 8th Floor
San Francisco CA 94143

☐ **Pediatric**
UCSF Benioff Children's Hospital
1825 4th Street, 6th Floor
San Francisco, CA 94158

PATIENT INFORMATION

Patient first name: _____ Last name: _____

DOB: _____

Home phone: _____ ☐ Work phone or ☐ Cell phone: _____

Parent/Caregiver: _____ Email: _____

Street address: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

❑**Include copy of insurance card (both sides)**

Subscriber name: _____

Health plan: _____ Member ID: _____

Group #: _____ Authorization #: _____

Secondary Insurance, if any: _____

REFERRAL INFORMATION

Diagnosis/ICD 10: _____ Date of onset: _____

Reason for referral: _____

Symptoms: _____

List of neuroactive medications and dosage: _____

REFERRING PHYSICIAN INFORMATION

Referring MD: _____ NP#: _____

Phone: _____ Fax: _____

Signature: _____

APRIL2021