2012 Justin Rd, Suite 200-H, Highland Village, TX 75077
877-944-2111 office www.integrisneuro.com

Intermittent EEG Monitoring Request

Patient Name: _____

Patient Guardian's Name (if applicable): _____

DOB: _____ / _____ / _____ **SEX**: ☐ Male ☐ Female

Patient Address: _____

Patient Cell Phone #: (_____) _____ - _____

Alternate phone #: (_____) _____ - _____

Permission from Patient to use Text Messaging (Circle One): ☐ YES ☐ NO

(**NOTE**: If patient is under 21 or has legal guardian the same information will be needed for that person as listed above. Include in Special Considerations below).

Setup date: _____ / _____ / _____

Setup time: _____:_____ ☐ AM ☐ PM

Time zone: ☐ PST ☐ MST ☐ CST ☐ EST

How many test days will be collected? ☐ 2 Day ☐ 3 Day ☐ 4 Day, or _____ Day

Referring physician: _____

Reading Physician: _____

Name of Your Practice:

Patient's Local Police Department Name: _____

Patient's Local Police Department Contact #: (_____) _____ - _____

Special considerations: _____
_____
_____
_____
_____

Please fax to 877-492-1768
at least **48 hours** before patient setup