



How to Submit Your Intermittent Monitoring Requests Online

You are always welcome to submit your orders via fax to either: 877-492-1768 or 877-944-2111, however if you prefer to submit your orders online go to <https://www.integrisneuro.com/order-forms> and follow the instructions below.

1. Click on the **“Submit Online”** below the name of the order type you would like to submit.

A screenshot of a web browser displaying the Integris Neuro website. The browser's address bar shows "integrisneuro.com/order-forms". The website header includes the Integris Neuro logo and navigation links for Home, Order Forms, Physician Login, and About Us. Below the header, there are instructions: "Click Order Form Below to Download PDF" and "Click **Submit Online** below to Submit Online Order". Three order form options are presented as thumbnails: "Video EEG Order", "Routine EEG Order", and "EEG Intermittent Monitoring Request". Each thumbnail has a blue "Submit Online" button. The "Submit Online" button for the "EEG Intermittent Monitoring Request" is circled in red. At the bottom of the page, there is a dark blue footer with the Integris Neuro logo, copyright information "© 2021 INTEGRIS NEURO LLC All Rights Reserved", and a Facebook icon.

2. Enter your name and email address, then click on the “Get Started” button.

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pdffiller.com/en/link_to_fill/720727538.htm

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Additional Authentication Required

The sender has requested your authentication for this document.

1. Please provide us with your name and email address to ensure secure authentication.

Name Email Address

Your use of this site is subject to [Terms of Service](#)

Accessibility mode GET STARTED >

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INTEGRIS NEURO

2018 January 03, 2018 2018 01 03 10:00 AM EST 720727538.htm

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 Consideration below.)

Setup date: ____/____/____

Setup time: ____:____:____ AM PM

Time zone: PST MST CST EST

How many test days will be collected? 1 Day 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 consideration: _____

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

3. Click on the orange “I Consent” button at the bottom of the screen

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Electronic Record and Signature Disclosure

Agreement to do business with **Integris Neuro**

Electronic Record and Signature Disclosure

From time to time, **Integris Neuro** (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through the airSlate, Inc. (airSlate) electronic signing system. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the "I Consent" button below.

- All notices and disclosures will be sent to you electronically**

We will be providing you via electronic mail to the your email address of all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you.

- Valid and current email address, notification and updates**

Your current valid email address is required in order for you to continue to use airSlate signing system and receive notices and disclosures as required by law. After you complete this document, you will be prompted to enter your email address. You must enter your email address. You agree to keep **Integris Neuro** and airSlate informed of any changes in your email address. To advise **Integris Neuro** of a change in your e-mail address, please send an email to admin@integrisneuro.com.

To let airSlate know of a change in your e-mail address, you must contact airSlate support team by email via support@airslate.com. It is your responsibility to check your email for Electronic Communications and to check for updates to this Agreement.

Send Disclosure over the email

I Consent

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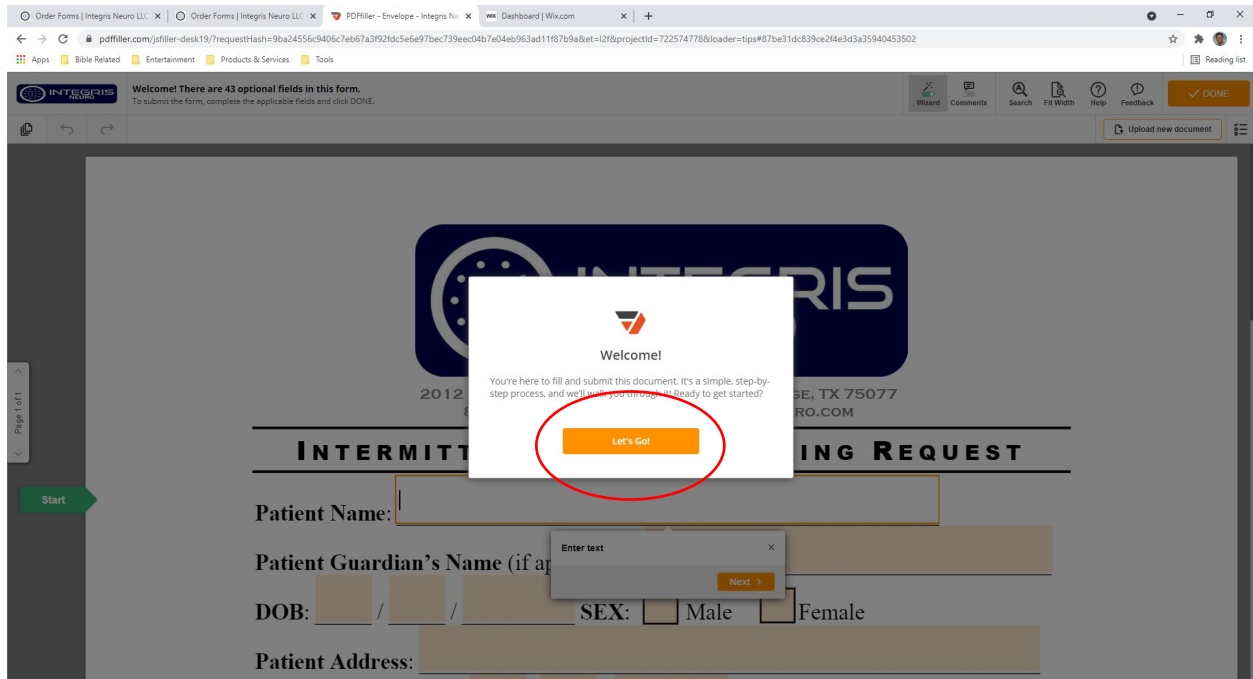
Patient's Local Police Department Name: _____

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

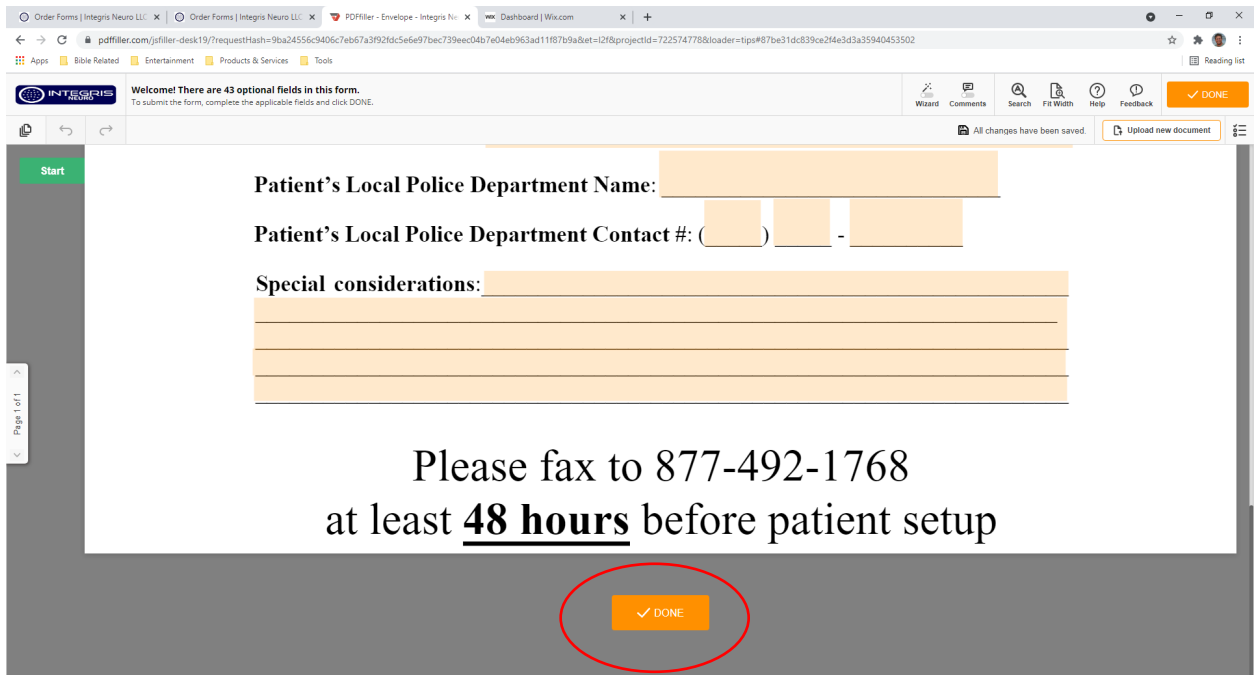
Special consideration: _____

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at least **48 hours** before patient setup

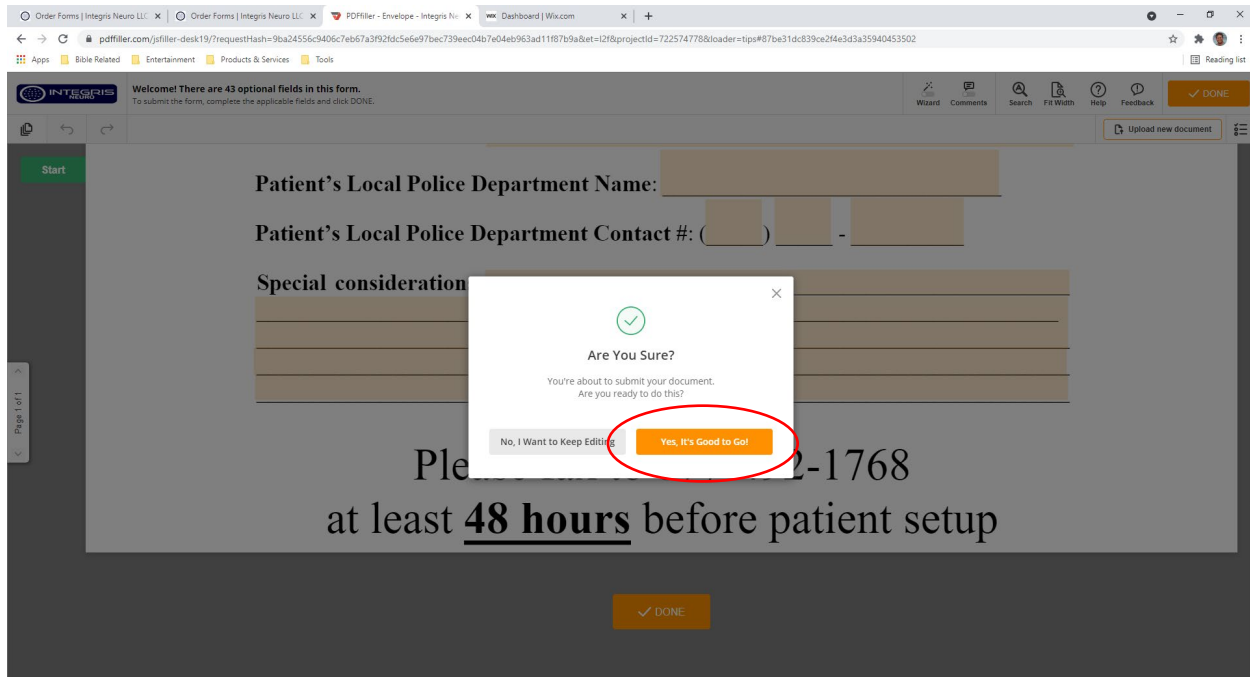
4. Click on “Let’s Go” button.



5. Complete the form including at least the sections indicated in RED and the ICD10 codes, and Click “DONE” button at the bottom of the screen.



6. When prompted click on the “YES, It’s Good to Go” button



7. Click on “ATTACH” buttons to attached PDF documents including Clinical Notes, Medication List, and Previous Routine EEG Report. When you have finished attaching the documentation click on the “Finish” button.

