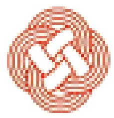

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Please check off which test below:

- ❑ **Routine**
- ❑ **Sleep-Deprived (SD)**
- ❑ **Ambulatory EEG (Please circle how long) 24 Hrs 48 Hrs 72 Hrs**
- ❑ **Longer Recording (Please circle how long) 60 Min 120 Min 180 Min**

Brief Clinical Info. ____

____

____

____

Medication ____

____

☐ See Attached Medication List

Ordering Physician: __________________________________ **Billing #:** ___________________
(Please Print)

Date:_________________________ Signature:____

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Please note we need 24 hours notice of cancellation or you will be charged $25.00. Missed appointments will also be charged $25.00.

Please give your patient the **attached instruction sheets** and we will contact your patient directly with appointment time. Thank you.