Mass General Brigham
Salem Hospital

**NEURODIAGNOSTIC TESTING REQUEST FORM**
**Pediatric EEG**
Please fax the completed form to **(978) 740-4880**

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Patient Name: _____ DOB: _____

Parent or Guardians Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

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Primary Insurance: _____ID# _____

Subscriber: _____

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Reason for testing: _____
_____
_____

Prior EEG Testing: Yes ☐ No ☐

Date: _____ Location: _____

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Ordering Physician: _____ Phone:_____Fax:_____

Primary Physician: _____ Phone:_____Fax:_____

**Ordering MD Signature:** _____ Date of Exam: _____

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*For Office Use Only*

Date of EEG: _____ Time: _____

☐ Inpatient ☐ Outpatient ☐ Urgent