NeuroDiagnostic Laboratories

Phone Number: (602) 424-4450
Scheduling Fax: (602) 424-4451
Alt. Scheduling Fax: (602) 926 - 2724
Scheduling Email: faxes@ndxlabs.com

Date: _____

NeuroDiagnostic Sleep Centers

EMG/NCV TESTING:

Incl. Nerve Conduction & Electromyography

☐ Upper Extremity
☐ Right ☐ Left ☐ Bilateral
☐ Lower Extremity
☐ Right ☐ Left ☐ Bilateral
☐ Facial

Patient on Blood Thinners ☐ Yes ☐ No
INR Level_____

☐ Add Neurology Evaluation/Consultation to test selected above

Typical Indications for EMG/NCV:
• Pain • Numbness or Tingling • Burning • Weakness

VNG TESTING

Videonystagmography

☐ VNG

Typical Indications for VNG:
• Dizziness • Peripheral Vertigo, Unspecified
• Benign Positional Vertigo • Vertigo of Central Origin • Imbalance

EEG TESTING

Electroencephalography

☐ EEG
☐ Ambulatory EEG:
☐ 24hr ☐ 48hr ☐ 72hr
☐ Video Monitoring Ambulatory EEG

Typical Indications for EEG:
• Headaches • Memory Loss
• Seizures/Convulsions, Non-Specific • Syncope

Has your patient had a previous sleep study? ☐ Yes ☐ No
If yes, previous results are: ☐ Included ☐ Not Available

SYMPTOMS: (Please check all that apply)

☐ Witnessed Apnea
☐ Obesity
☐ Hypertension
☐ Excessive Daytime Sleepiness / Fatigue
☐ Periodic Limb Movement (RLS)
☐ Choking / Gasping Associated with Awakening
☐ Persistent / Frequent Snoring
☐ Diabetes
☐ COPD
☐ Cardiovascular Disease
☐ Patient on O2 Therapy
☐ Insomnia

Other: _____

DIAGNOSTIC SLEEP STUDIES:

(Please select one from the list below)

In Lab Sleep Study
(PSG)
☐ With Consultation
☐ Without Consultation*

In Lab Split Night Study
(PSG & Titration)
☐ With Consultation
☐ Without Consultation*

Home Sleep Study
(HST)
☐ With Consultation
☐ Without Consultation*

In Lab Titration
☐ With Consultation
☐ Without Consultation*

* If diagnostic sleep study is performed without **consultation**, the referring physician will be responsible for managing the patient through the sleep process including all therapy and follow-up.

☐ Additional Medical Request:

PLEASE INCLUDE: ☐ **Photocopy of Front & Back of Insurance Card** ☐ **All Relevant Notes Dating Back 90-Days**

Patient Name:_____ **Phone:**_____

DOB:_____ Alt Phone: _____

Primary Language: ☐ **English** ☐ **Spanish** ☐ **Other Language:** _____

Insurance:_____ Policy No:_____

Referring Provider:_____ Referring Clinic: _____

Referral Coordinator:_____ Fax:_____ Phone:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Referring Provider Signature:_____

For locations and access to online referral forms, please visit: **www.ndxlabs.com**