

EEG Scheduling Form

Patient Information

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (*circle preferred*): _____ Work: _____ Cell: _____
Primary Insurance: _____ Primary Insurance ID#: _____
Secondary Insurance: _____ Secondary Insurance ID#: _____
Parent(s)/Legal Guardian(s): _____

Ordering Clinic Information

Ordering Clinic Contact Name: _____
Contact Number: _____
Ordering Physician: _____
Diagnosis: _____

History of Symptoms: _____

Medications: _____
Comments: _____

Type of EEG: Routine

Provider Signature

Date

Time

Please fax this completed EEG order form to the Boys Town OPDS at 531-355-0026.
Our schedulers will contact the patient or patient's family to give testing instructions
and schedule testing. Scheduling is done 8:00 a.m. - 5:00 p.m.

14040 Hospital Road • Boys Town, NE 68010
Phone: 531-355-6737 • Fax: 531-355-0026
boystownhospital.org

