Evoked Potential Requisition
SMH 453 MR

1	PATIENT INFORMATION

Patient Name: _____

D.O.B.:_____ Age: _____

Patient Phone #: _____ MRN:_____

Address: _____ Zip _____

Insurance Type: _____ Contract #:_____

Office Use: Appointment Date: _____ Time: _____

2	Location:	3	Test Type:
	Outpatient Inpatient (floor:_____) Intraoperative Monitoring		VER Acuity - Right Eye:_____ Left Eye: _____ MN SSEP PTN SSEP BAER Other _____
4	Primary DIAGNOSIS: Brief description of problems, patient history and questions to be addressed. ICD-9 Code: _____		
5	Prior EP Studies:		
6	Type of Surgery:		
7	Surgery Date:	8	Pre-Op Date: _____Pre-Op Time: _____

9 Surgeon:

10

14 Caller's Name: _____

Caller's Phone #: _____