



rEEG REQUISITION FORM

Please fax this form to CNS Response upon scheduling rEEG testing at 866-294-2611.

Patient's Last Name:		First:	Middle:	Date of Birth:
<input type="checkbox"/> Male <input type="checkbox"/> Female	Handedness: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both		Resting Pulse (Required):	Date of Test:
Weight:		Referring Physician:		Physician's Telephone:
				Physician's Fax:

SERVICES ORDERED

- Type I Test (**Initial**, Medication Free) Type II Test (**Follow-up**, On Medications)
 Type I(m) (**Initial**, Medicated, Requires Pre-approval)

Clinical Global Impression Scale (Circle one only)

- 0 -- Patient not assessed
- 1 -- Normal, not at all ill
- 2 -- Borderline mentally ill
- 3 -- Mildly ill
- 4 -- Moderately ill
- 5 -- Markedly ill
- 6 -- Severely ill
- 7 -- Among the most extremely ill patients

Clinical Global Improvement Scale (circle one only)

- 1 – Patient very much improved
- 2 – much improved
- 3 – minimally improved
- 4 – unchanged
- 5 – minimally worse
- 6 – much worse
- 7 – very much worse

TYPE I MEDICATION LIST: Listing ALL medications or supplements (including non-psychotropic):

Medication(s) or Supplement(s)	Daily Dosage	Mark if NOT Stopped	Number of Days Meds Stopped For:	EEG tech (Initial to confirm)

Note: In a Type I test, the patient must be medication free for at least 5 half-lives of any medication taken unless previously arranged with CNS Response. Please check your physician guide for specific guidelines or call for special circumstances.

REQUIRED TYPE II and I(m) MEDICATION LIST: List all medications present at time of Type II testing or else that have been confirmed to be appropriate by CNS Response at time of Type I testing:

Medication Name	Daily Dosage	Serum Drug Level	EEG tech (Initial to confirm)

Patient Name: _____

DIAGNOSIS: Check off any applicable Major Category.

If possible, please make a more specific diagnosis by choosing *one* primary diagnosis and *any* applicable secondary diagnoses from list below:

I°	II°			I°	II°		
<input type="checkbox"/> MOOD DISORDER				<input type="checkbox"/> DISORDERS USUALLY OF CHILDHOOD			
<input type="checkbox"/>	<input type="checkbox"/>	296.2x	Major Depressive Episode	<input type="checkbox"/>	<input type="checkbox"/>	307.23	Tourette's Disorder
<input type="checkbox"/>	<input type="checkbox"/>	296.3x	Major Depression, Recurrent	<input type="checkbox"/>	<input type="checkbox"/>	312.8	Conduct Disorder
<input type="checkbox"/>	<input type="checkbox"/>	300.4	Dysthymic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	313.81	Oppositional Defiant Disorder
<input type="checkbox"/>	<input type="checkbox"/>	311	Depressive Disorder NOS	<input type="checkbox"/>	<input type="checkbox"/>	312.9	Disruptive Behavior Disorder
<input type="checkbox"/>	<input type="checkbox"/>	296.7	Bipolar I Disorder (recent episode unspecified)	<input type="checkbox"/>	<input type="checkbox"/>	314.9	Attention Deficit Hyperactivity Disorder NOS
<input type="checkbox"/>	<input type="checkbox"/>	296.89	Bipolar II Disorder	<input type="checkbox"/>	<input type="checkbox"/>	299.90	Autistic Disorder
<input type="checkbox"/>	<input type="checkbox"/>	301.13	Cyclothymic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	299.80	Pervasive Developmental Disorder NOS
<input type="checkbox"/>	<input type="checkbox"/>	296.80	Bipolar Disorder NOS	<input type="checkbox"/>	<input type="checkbox"/>	315.90	Learning Disorder NOS
<input type="checkbox"/>	<input type="checkbox"/>	296.90	Mood Disorder NOS	<input type="checkbox"/> PERSONALITY DISORDER			
<input type="checkbox"/> ANXIETY DISORDER				<input type="checkbox"/>	<input type="checkbox"/>	301.0	Paranoid Personality Disorder
<input type="checkbox"/>	<input type="checkbox"/>	300.01	Panic Disorder with agoraphobia	<input type="checkbox"/>	<input type="checkbox"/>	301.20	Schizoid Personality Disorder
<input type="checkbox"/>	<input type="checkbox"/>	300.21	Panic Disorder without agoraphobia	<input type="checkbox"/>	<input type="checkbox"/>	301.22	Schizotypal Personality Disorder
<input type="checkbox"/>	<input type="checkbox"/>	300.29	Specific Phobia	<input type="checkbox"/>	<input type="checkbox"/>	301.7	Antisocial Personality Disorder
<input type="checkbox"/>	<input type="checkbox"/>	300.23	Social Phobia	<input type="checkbox"/>	<input type="checkbox"/>	301.83	Borderline Personality Disorder
<input type="checkbox"/>	<input type="checkbox"/>	300.3	Obsessive-Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	301.50	Histrionic Personality Disorder
<input type="checkbox"/>	<input type="checkbox"/>	309.81	Post-traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>	301.81	Narcissistic Personality Disorder
<input type="checkbox"/>	<input type="checkbox"/>	308.3	Acute Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>	301.82	Avoidant Personality Disorder
<input type="checkbox"/>	<input type="checkbox"/>	300.02	Generalized Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>	301.6	Dependent Personality Disorder
<input type="checkbox"/>	<input type="checkbox"/>	300.00	Anxiety Disorder NOS	<input type="checkbox"/>	<input type="checkbox"/>	301.4	Obsessive-Compulsive Personality Disorder
<input type="checkbox"/> SOMATOFORM DISORDER				<input type="checkbox"/>	<input type="checkbox"/>	301.9	Personality Disorder NOS
<input type="checkbox"/>	<input type="checkbox"/>	300.81	Somatization Disorder	<input type="checkbox"/> SEXUAL DISORDER			
<input type="checkbox"/>	<input type="checkbox"/>	300.11	Conversion Disorder	<input type="checkbox"/>	<input type="checkbox"/>	302.6	Gender Identity Disorder NOS
<input type="checkbox"/>	<input type="checkbox"/>	307.xx	Pain Disorder	<input type="checkbox"/>	<input type="checkbox"/>	302.90	Paraphilia NOS
<input type="checkbox"/>	<input type="checkbox"/>	300.7	Hypochondriasis	Specify Type:			
<input type="checkbox"/>	<input type="checkbox"/>	300.7	Body Dysmorphic Disorder	<input type="checkbox"/> DISSOCIATIVE DISORDER			
<input type="checkbox"/>	<input type="checkbox"/>	300.81	Somatoform Disorder NOS	<input type="checkbox"/>	<input type="checkbox"/>	300.15	Dissociative Disorder NOS
<input type="checkbox"/> EATING DISORDER				Specify Type:			
<input type="checkbox"/>	<input type="checkbox"/>	307.1	Anorexia Nervosa	<input type="checkbox"/> SLEEP DISORDER			
<input type="checkbox"/>	<input type="checkbox"/>	307.51	Bulimia Nervosa	<input type="checkbox"/>	<input type="checkbox"/>	307.47	Dyssomnia NOS
<input type="checkbox"/>	<input type="checkbox"/>	307.50	Eating Disorder NOS	<input type="checkbox"/>	<input type="checkbox"/>	347	Narcolepsy
<input type="checkbox"/>	<input type="checkbox"/>	309.xx	Adjustment Disorder	<input type="checkbox"/>	<input type="checkbox"/>	307.47	Parasomnia NOS
<input type="checkbox"/> PSYCHOTIC DISORDER				<input type="checkbox"/> DEMENTIA			
<input type="checkbox"/>	<input type="checkbox"/>	295.xx	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	290.xx	Dementia
<input type="checkbox"/>	<input type="checkbox"/>	295.70	Schizoaffective Disorder	<input type="checkbox"/> OTHER			
<input type="checkbox"/>	<input type="checkbox"/>	297.10	Delusional Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Other:	Specify:
<input type="checkbox"/>	<input type="checkbox"/>	298.9	Psychotic Disorder NOS	<input type="checkbox"/>	<input type="checkbox"/>	Other:	Specify:
<input type="checkbox"/> SUBSTANCE USE DISORDER							
<input type="checkbox"/>	<input type="checkbox"/>	303.90	Alcohol Dependence (indicates tolerance and withdrawal)				
<input type="checkbox"/>	<input type="checkbox"/>	305.00	Alcohol Abuse				
<input type="checkbox"/>	<input type="checkbox"/>	304	Drug Dependence (Check all appropriate)				
			<input type="checkbox"/> Amphetamine <input type="checkbox"/> Cannabis <input type="checkbox"/> Cocaine <input type="checkbox"/> Hallucinogens <input type="checkbox"/> Inhalants <input type="checkbox"/> Opioids <input type="checkbox"/> PCP <input type="checkbox"/> Sedatives				
<input type="checkbox"/>	<input type="checkbox"/>	305	Drug Abuse (Check all appropriate)				
			<input type="checkbox"/> Amphetamine <input type="checkbox"/> Cannabis <input type="checkbox"/> Cocaine <input type="checkbox"/> Hallucinogens <input type="checkbox"/> Inhalants <input type="checkbox"/> Opioids <input type="checkbox"/> PCP <input type="checkbox"/> Sedatives				

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Physician or Authorized Representative's Name	Date
<p>I understand that the accuracy of the medication and dosage information reported above is essential to the development of an accurate Referenced-EEG report by CNS Response. I confirm that the patient has been instructed to discontinue all medications at least five half-lives prior to rEEG testing unless medications have been pre-approved by CNS Response and that the patient does not have any exclusion to testing (criteria listed in Guide to Physicians for rEEG).</p>	

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(EEG Technician Signature)	Date
<p>I, the EEG Technician, have verified with the patient that the information in the Type I & II medications tables are correct. I have also verified that the patient has not had alcohol for 2 days, nicotine for 10 hrs, or caffeine for 15 hours, or any other medications or supplements.</p>	