



5601 Warren Parkway
Frisco, TX 75098
www.bmcf.com

EEG LAB
FAX 214-407-9525
Phone 214-407-5291

Scheduling Form

Date _____

Patient Name _____ Date of Birth _____

Home Phone: _____ Alternate/Cell _____

Male ____ Female ____

Circle Procedure Below

EEG AWAKE/DROWSY

EEG AWAKE/ASLEEP

AMBULATORY EEG
HRS 24 48 72 96

Diagnosis (reason for study) _____

ICD9 Code (required) _____

Physician to Read _____

Ordering Physician Name _____

Ordering Physician Signature _____

- Patients must register at the Imaging Department Registration Desk prior to the procedure. Please arrive 15 minutes early to allow for registration.
- Patients will be contacted to schedule testing.
- Please give patient a copy of this form.