CNS Neuromonitoring Request Form
4000 Church Road, Mt Laurel, NJ 08054
Phone: 856-234-4570 **Reference #**

Please Fax to: 856-494-7994

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ SEX: _____ SS #: _____

HOME PHONE: _____ WORK PHONE: _____

DATE OF SURGERY: _____ TIME OF SURGERY: _____

HOSPITAL: _____ SCHEDULED DURATION: _____

SURGEON: _____ ASSISTANT (if known): _____

DIAGNOSIS (Description and ICD-9) ***Procedure Planned***

1: _____ 1: _____

2: _____ 2: _____

TYPE OF MONITORING REQUESTED (PLEASE CIRCLE ALL APPLICABLE)

[SSEP / EMG / MEP / EEG] DERMATOMES PEDICLE SCREW CRANIAL NERVES

SPECIAL REQUESTS:

_____

INSURANCE INFORMATION

PRIMARY INSURANCE CO.: _____Personal_____No Fault____Work Comp_____

POLICY #: _____ GROUP #: _____

PRECERTIFICATION: _____ DATE: _____

RELATION TO INSURED: _____

SECONDARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

PRECERTIFICATION: _____ DATE: _____

(SCHEDULER: PLEASE ALSO FAX THE SURGICAL CONSENT SIGNED BY THE SURGEON REQUESTING THE INTRAOPERATIVE MONITORING)

Scheduler's Name: _____ Scheduler's Phone: _____

FOR CNS NEUROMONITORING

RECEIVED AND AKNOWLEDGED BY: _____
(If this form is not returned to your facility with a signature within 24 hours please re-send)

Please check if:

- ☐ **Patient is rescheduled**
- ☐ **Patient cancelled**
- ☐ **Tech notified e-mail or phone By whom_____**