



UNIVERSITY NEUROLOGISTS P.S.C
 NEURODIAGNOSTICS LABORATORY
 401 EAST CHESTNUT ST. SUITE 510
 LOUISVILLE, KY 40202

Located at the UofL Healthcare Outpatient Center

PHONE (502) 589-0802 FAX (502) 589-0805
 * PLEASE ATTACH RECENT PATIENT DEMOGRAPHICS & INSURANCE INFORMATION TO EXPEDITE SCHEDULING*

Patient Name: _____ **D.O.B:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

DIAGNOSES: _____

Please provide the diagnoses (signs, symptoms, reason for referral) including codes, and other pertinent clinical information.

WHERE WOULD YOU LIKE THE RESULTS TO BE SENT UPON COMPLETION? *Default is sent to ordering physician*

Fax: _____ E-Mail: _____ Mailing Address: _____

Today (if schedule permits) To be scheduled _____

DIAGNOSTIC ULTRASOUND	ELECTROENCEPHALOGRAPHY (EEG)
<input type="checkbox"/> Carotid Duplex (extracranial artery study) <input type="checkbox"/> Transcranial Doppler (TCD - intracranial artery study) <input type="checkbox"/> Peripheral Nerve/Muscle Ultrasound	<input type="checkbox"/> Routine EEG <input type="checkbox"/> Sleep-deprived EEG <input type="checkbox"/> 4 Hr. Video-EEG @ UofL Hospital <input type="checkbox"/> Inpatient Video-EEG @ UofL Hospital <small>(Scheduled after chart review by team physician)</small>
PERIPHERAL NERVE & MUSCLE TESTING	ADDITIONAL TESTING
<input type="checkbox"/> Nerve Conduction Studies (NCS) with or without Electromyography (EMG) <ul style="list-style-type: none"> • Pediatric studies may be performed in the Kosair sedation suite; call 629-6200 to schedule <input type="checkbox"/> Repetitive Nerve Stimulation (e.g., to diagnose myasthenia gravis) <input type="checkbox"/> Single-fiber EMG <input type="checkbox"/> Blink Reflex Testing	<input type="checkbox"/> Somatosensory Evoked Potentials <ul style="list-style-type: none"> <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Visual Evoked Potentials <input type="checkbox"/> Brainstem Auditory Evoked Potentials <input type="checkbox"/> Lumbar Puncture <small>(requires lab order for same-day CBC and INR)</small> <input type="checkbox"/> Skin Biopsy For Small Fiber Neuropathy <input type="checkbox"/> Autonomic Testing (Heart-rate variability, sympathetic skin response)

Comments: _____

Name of Practice/Medical Facility: _____

Ordering Physician: _____ **NPI #:** _____ **Date:** _____

Physician Signature: _____ **Date:** _____

Neurodx Order Form rev 2010-05-05

Additional copies of this form are available at
<https://louisville.edu/medschool/neurology/files/NeurodiagnosticsOrderForm.pdf>