STRONG HEALTH
STRONG MEMORIAL HOSPITAL
Neurophysiology Lab
601 Elmwood Avenue, Box 673
Rochester NY 14642
Phone (585) 275-2775 - Fax (585) 442-4329

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	Surgeon's phone:
11	Referring Physician:	12	Referring physician phone number:
13	Today's Date:	14	Caller's Name: _____ Caller's Phone #: _____