EPILEPSY MONITORING UNIT ADMISSION REQUEST SHEET

SECTION TO BE COMPLETED BY MD/NP

Patient Name:	

Admission Urgency (Please "X") / **Reason for Admission (Please "X")**

	Admission Urgency		Reason for Admission
	Emergent		Classify and characterize seizures
	Urgent		Pre-surgical diagnostic evaluation
	Elective		Management of acute seizure exacerbation
			Management of medication toxicity

Tests required during hospital admission: (Please "X")

	Test
	Brain MRI/MRA W/WO Contrast
	PET scan-interictal with EEG recording
	Ictal/interictal SPECT scan
	Blood testing/spinal tap/others
	Consultation:
	Neuropsychological Testing

SECTION TO BE COMPLETED BY OFFICE

Epilepsy Center Attending:	
Referred By:	

Demographics:

DOB:		Age:	
Unit No.:		M/F:	
Language at Home:		Address:	
Home Ph:		Work Ph:	

Primary Insurance:		ID#:		Tel #:	
Secondary Insurance:		ID#:		Tel #:	

Admission Source (Please "X")

	Source		Source
	Private Office		ER
	Clinic		Transfer

Admission Date:		# of days:	
Date Letter Mailed:			

Verification Date:	Notes

Precert Date:		Notes
Precert No:		
# of Days:		

** ALSO REQUIRED: Consult Note, Copy of Insurance Card, and AOB
FAX BACK TO WIL CABRERA AT 212-305-5445 OR EXT. 5-5445
IF YOU HAVE ANY QUESTIONS CALL 212-305-1742