



BIOTRONIC

NEURAL MONITORING SPECIALISTS

REQUEST FOR ELECTROPHYSIOLOGICAL MONITORING SERVICES

Date of Request: _____ Time: _____ AM / PM Physician's Contact Person _____

Physician Name: _____ Office Phone: _____ Confirmation
Number _____

Hospital: _____ Surgery Date: ____ / ____ / ____ Time: _____ AM / PM Duration: _____

Surgical Procedure Information: _____

Diagnosis: _____

Type of Modalities Needed: check all that apply

Spinal Cord/Nerve Root
SEP- ____ EMG- ____ TcMEP- ____

Acetabulum/Sciatic Nerve
SEP- ____ EMG- ____ Pedicle Screw Stim- ____

Cerebrovascular/Carotid
SEP- ____ EMG- ____ TCD- ____ EEG- ____

Peripheral Nerve
EMG- ____ NAP- ____ SEP- ____

Other: _____

Skull Base/Cranial Nerve
Auditory (BAER)- ____
Cranial Nerve(s)- ____ 3 4 5 6 7 8 9 10 11 12
SEP- ____ VEP- ____

Cortical Mapping
EEG- ____
Motor Mapping (MCM)- ____
Language Mapping (LCM)- ____
Sensory Mapping (SCM)- ____

D-Waves (DERM)- ____

PATIENT INFORMATION

Last Name: _____ First Name: _____

Social Security #: _____ - _____ - _____ Address: _____

City, State & Zip: _____

Home #: (____) _____ - _____ Work #: (____) _____ - _____ Date of Birth: ____ / ____ / ____

PLEASE FAX REFERRAL SHEET TO (866) 634-2766

Biotronic will call to confirm the scheduled monitoring service one business day prior to date of surgery.

CASES WITHOUT CONFIRMATION NUMBERS ARE NOT SCHEDULED

Please feel free to contact us at (800) 638-7564 if you do not receive a confirmation number.

812 Avis Drive
Ann Arbor, MI 48108
Office: (800) 638-7564
Fax: (866) 634-2766