Neuro Medical Care
ASSOCIATES, PLLC
52 Harrison St 2nd Floor Johnson City, New York 13790

INTRAOPERATIVE NEUROMONITORING REQUEST FORM

SCHEDULER NAME | TODAY'S DATE

SCHEDULER PHONE | SCHEDULER FAX | SCHEDULER E-MAIL

SURGERY FACILITY NAME | SURGEON

SURGERY DATE | SURGERY TIME | SCHEDULED DURATION

SURGERY DATE

PATIENT NAME | PATIENT DOB | PATIENT SS# | PATIENT GENDER ☐ M ☐ F

PATIENT INSURANCE COMPANY | INSURANCE POLICY OR CLAIM # | INSURANCE PRECERT #

PATIENT EMPLOYER | PATIENT DIAGNOSIS

ICD-9 | TYPE OF PROCEDURE

TYPE OF MONITORING REQUIRED:

☐ SSEP ☐ MEP ☐ EMG ☐ CSA/EEG ☐ VEP ☐ BAEP Other:

DERMATOMES ☐ Yes ☐ No PEDICLE SCREW STIMULATION ☐ Yes ☐ No FACIAL NERVES ☐ Yes ☐ No

CRANIAL NERVES ☐ Yes ☐ No INSTRUMENTATION ☐ Yes ☐ No LARYNGEAL NERVE ☐ Yes ☐ No

SPECIAL REQUIREMENTS

Fax form to 607-607-729-7320 Attention: IOM Scheduling Team

THIS SECTION FOR NEURO MEDICAL CARE ASSOCIATES USE ONLY

CONFIRMATION # | NEUROLOGIST | FAXED TO REQUESTOR BY/DATE