SYNAPSES IOM

NEUROMONITORING CASE REQUEST FORM

Fax: 248-254-6524
Email: casescheduling@synapsesiom.com

Synapses IOM strives to remain compliant with all HIPAA/HITECH regulations. Please transmit all protected health information securely.

PHONE CONTACT: (866) 76-NERVE

Scheduler

Name of Person submitting request form: _____

Date: (/ /) Phone: ( ) - Fax: ( ) -

Patient Information

Date of Surgery: (/ /)

Hospital/Facility: _____ Surgeon:_____

Surgery Start Time: _____ AM / PM (circle) Duration: _____ (hours)

Patient Name: _____ Patient DOB: (/ /)

Primary Insurance Carrier _____

Secondary Insurance Carrier _____

Surgery Authorization Number _____

Please include front and back copies of all insurance cards

Diagnosis ICD-10 codes: _____

Procedure: _____

Type of Monitoring

Type of Monitoring Requested (check all that apply):

- ☐ **SSEP** (SomatoSensory Evoked Potentials)
- ☐ **EMG** (Electromyography)
- ☐ **TcMEP** (Transcranial Motor Evoked Potentials
  - **CONTRAINDICATIONS for TcMEP Testing** (cochlear implant, brain implant)
  - **SAFETY CONSIDERATIONS for TcMEP Testing**
  (history of seizure, pacemaker, skull defects, unstable cervical spine)
- ☐ **EEG** (Electroencephalography)
- ☐ **VEP** (Visual Evoked Potentials)
- ☐ **SCM** (Sensory Cortical Mapping)
- ☐ **MCM** (Motor Cortical Mapping)
- ☐ **ABR / BAEP – CN VIII** (Brainstem Auditory Evoked Response)
- ☐ **Upper CN EMG** (Cranial Nerve Electromyography – **check all that apply**)
  ☐ III ☐ IV ☐ V ☐ VI ☐ VII
- ☐ **Lower CN EMG** (Cranial Nerve Electromyography – **check all that apply***)*
  ☐ *IX* ☐ *X* ☐ *XI* ☐ *XII*
- ☐ **FNM – CN VII** (Facial Nerve Monitoring)
- ☐ **RLN – CN X (**Recurrent Laryngeal Nerve Monitoring)
- ☐ **OTHER REQUESTS** (please specify) _____

_____

_____