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Rocky Mountain Neurology

Testing Order Form (Physician use ONLY)

Patient Name: _____

Date of Birth: _____ Patient Phone Number: _____

Insurance: _____

Referring Physician: _____

Order Information

- ☐ EEG
- ☐ Ambulatory EEG
- ☐ EMG/ NCS (Including what extremities)
- ☐ Neurobehavioral Testing

Diagnosis: _____

EMG/NCS Extremity: _____

****Faxed orders MUST include demographics, copy of ID and insurance cards, last office visit notes and any other important records****

Order Fax: 866-383-0569

****PLEASE NOTE: Orders can take up to 3 business days to process and contact patients****