SWEDISH MEDICAL CENTER

TeleEEG Form

Name of contracted site requesting consultation: _____
Date of request: _____

Contracted facilities must complete and fax this form, along with the requested documents listed below, prior to receiving TeleEEG service from Swedish Medical Center.

Fax Instructions

Please print clearly and provide complete, current and accurate information. Fax the completed form, along with the additional requested documents, to:

Swedish Registration (fax: 206-386-2625). In the fax, please include the following documents:

1. Completed TeleEEG Form
2. Copy of the Patient Information Sheet (face sheet)
3. Photocopy of the patient identification (ID) if available

If you have questions or problems faxing, please call:
Patient Registration, Swedish/First Hill (Phone: 206-386-2561; press "3", and then "3" again)

Patient Legal Last Name:	Legal First Name:	Middle Initial Only:
Date of Birth:	Social Security Number:	
Address:		
Chief Medical Complaint:		
Referring Physician Name : Referring Physician Phone Number:		
Swedish Medical Center Use Only		
Patient Registration Section: **Registrar Name:** _____ **Completion Date:** _____ **Time:** _____ **MRN:** _____		