

EMG REFERRAL FORM

Referring Clinic Information:

Clinician Name, Address, City/Postal Code, Phone number, Fax number, PRACID:

Patient Information:

Name, Date of Birth, AHC#, Address, City/Postal Code, Phone number, Email:

Clinician Email : _____

Suspected Diagnosis:

- | | |
|---|--|
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Ulnar Neuropathy |
| <input type="checkbox"/> Cervical Radiculopathy | <input type="checkbox"/> Lumbosacral Radiculopathy |
| <input type="checkbox"/> Brachial or L/S Plexopathy | <input type="checkbox"/> Polyneuropathy |
| <input type="checkbox"/> Other _____ | |

Clinical Question: _____

Anticoagulant therapy or Bleeding disorder? Y N INR: _____ Platelets: _____

Infection: HIV Hepatitis B or C

Previous EMG:

Date: _____ Where: _____

To expedite the referral please provide:

- Patient's Medical History/ Copy of Cumulative Patient Profile
- Relevant imaging/consultation/operative reports
- List of current medications

Referral Physician Signature: _____ Date: _____

Print Name: _____