EMG Referral

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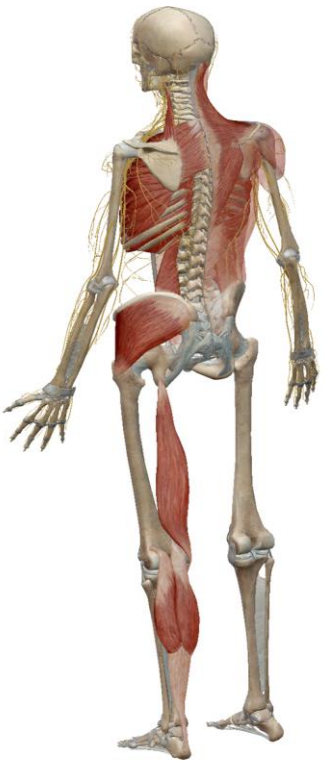

Patient Information:	**Referral Clinic Information:**
Patient Name:	Clinician Name:
Date of Birth:	Address:
AHC#:	City/Postal code:
Address:	Phone Number
City/Postal code:	Fax Number
Phone Number:	PRACID:
Email:	

Suspected Diagnosis:

- ❑ Carpal Tunnel Syndrome
- ❑ Ulnar Neuropathy
- ❑ Cervical Radiculopathy
- ❑ Lumbosacral Radiculopathy
- ❑ Brachial or L/S Plexopathy
- ❑ Polyneuropathy
- ❑ Other:

Clinical Question:

Pertinent History and Physical Examination:

Anticoagulant therapy or bleeding disorder: ❑ No ❑ Yes INR: Platelets:

Infection	Previous EMG
❑ HIV	Date:_____
❑ Hepatitis B or C	Where: _____

Referral Physician Signature: _____ Date: _____

Print Name: _____