



PATIENT INFORMATION

Patient Name

Date of Birth MM / DD / YYYY

AHC #

Address

City

Postal Code

Phone Number

Email

REFERRING PROVIDER

Provider Name

Address

City

Postal Code

Phone Number

Fax Number

PRACID

Email

SUSPECTED DIAGNOSIS

- | | |
|---|---|
| ☐ Carpal Tunnel Syndrome | ☐ Ulnar Neuropathy |
| ☐ Cervical Radiculopathy | ☐ Lumbosacral |
| ☐ Brachial or L/S Plexopathy | ☐ Radiculopathy |
| ☐ Other _____ | ☐ Polyneuropathy |

PRIORITY STATUS

- ☐ Urgent
☐ Semi-Urgent
☐ Routine

REASON FOR EMG ASSESSMENT

(Please include the area of numbness, tingling, pain, weakness, etc.)

RELEVANT HISTORY, PHYSICAL EXAMINATION & INVESTIGATION FINDINGS

APPROXIMATE ONSET OF SYMPTOMS

Anticoagulant therapy or Bleeding disorder? Yes ☐ No ☐ INR: _____ Platelets _____

If yes, state disorder & list medications:

Infection: ☐ HIV ☐ Hepatitis B or C

Defibrillator / Pacemaker: ☐ Yes ☐ No

Referral Physician Signature: _____

Date: _____

Print Name: _____