# Electrodiagnostic Requisition

**Appointment Date** ______________________
(yyyy/mm/dd)

**Time** ______________________
(hh/mm)

Fax: 905-687-3226

Previous EMG? Yes ❒ No ❒
If yes, where? ______________________

Inpatient? Yes ❒ No ❒
If yes, where? ______________________

| Patient Last Name | First Name |
|---|---|
| Patient Identification Number | |
| Address | |
| City | Phone Number ( ) |
| Postal Code | Work Phone Number ( ) |
| Birth Date (yyyy/mm/dd) | ❒ Male ❒ Female — Age |
| Health Card Number | WSIB |
| Ward | |

Transfers: Mechanical Lift? Yes ❒ No ❒ Needs assistance: 1 Person Assist ❒ 2 People Assist ❒

Clinical Diagnosis ______________________________________________

______________________________________________

Medication List ______________________________________________

Summary History and Physical Exam ______________________________________________

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______________________________________________

What questions do you wish to have answered by this exam? ______________________

______________________________________________

**TEST REQUESTED:** ❒ **Urgent** ❒ **Non Urgent**

| TEST REQUESTED | RATIONALE FOR EMG REFERRAL |
|---|---|
| ❒ EMG, Nerve Conduction Study and Electrodiagnostic Consultation<br>(other relevant electrodiagnostic techniques may be used)<br><br>❒ EMG, Nerve Conduction Study Only<br>(Provide review/summary or your neurological Examination and question you want answered) | ❒ Peripheral mononeuropathy<br>❒ Median nerve (carpal tunnel syndrome)<br>❒ Ulnar nerve<br>❒ Radial nerve<br>❒ Peroneal nerve<br>❒ Other<br>❒ Peripheral neuropathy<br>❒ Cervical radiculopathy<br>❒ Brachial plexopathy<br>❒ Lumbar radiculopathy<br>❒ Lumbo-sacral plexopathy<br>❒ Myopathy<br>❒ Neuromuscular junction disorders |

Physician Printed Name ______________________ Physician Signature ______________________

Copies to: ______________________ ______________________ ______________________