Hotel Dieu Shaver
HEALTH AND REHABILITATION CENTRE

Electrodiagnostic Requisition

Appointment Date _____
(yyyy/mm/dd)

Time _____
(hh/mm)

Please Fax To: 905-685-7703

Previous EMG? 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		

Clinical Diagnosis _____

_____

_____

_____

Medication _____

_____

Summary History and Physical Exam _____

_____

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 (other relevant electrodiagnostic techniques may be used) ❒ EMG, Nerve Conduction Study Only (Provide review/summary or your neurological Examination and question you want answered)	❒ Peripheral mononeuropathy: ❒ Median nerve (carpal tunnel syndrome) ❒ Ulnar nerve ❒ Radial nerve ❒ Peroneal nerve ❒ Other ❒ Peripheral Polyneuropathy ❒ Cervical radiculopathy ❒ Brachial plexopathy ❒ Lumbar radiculopathy ❒ Lumbo-sacral plexopathy ❒ Myopathy ❒ Neuromuscular junction disorders

Physician Printed Name _____ Physician Signature _____

Referring Physician Billing Number _____

Copies to: _____ _____ _____