Peripheral Nerve Clinic Referral Form

EMG Laboratory
Parkwood Institute, Main Building
St. Joseph Health Care London
550 Wellington Rd, London, ON N6C 0A7
P: 519 646-6100 ext. 65364
F: 519 646-6174

Please complete and fax this form to 519 646-6174

Patient information:
Name:
Date of Birth:
Address (including postal code):
Phone: (home and cell):
Ontario Health Card number.:
WSIB number:
Date of accident:
Area of injury:

Consultation request information:
Reason for consultation:

History:

Investigations/testing: (Attach all pertinent information. Have patient bring cd of imaging to appointment)

Please have patient bring a list of medications and all imaging.

Referring physician:
Address:
Phone number:
Fax number:

Family physician:
Address:
Phone number:
Fax number:

Signature of referring physician: Date: