EMG Clinic Requisition
Phone: 519-646-6157
Fax: 519-646-6174

Appointments Include EMG Nerve Conduction Studies and Consultation

Patient Information	**Referring Physician**
Name	Name
Date of Birth	Fax:
Address	Phone:
	Address:
Phone	**Family Physician**
OHIP#	Name:
WSIB Claim #	Address
Date of Accident	
Area of Injury	

History/Clinical Examination: PLEASE PROVIDE RELEVANT SYMPTOMS AND CLINICAL FINDINGS, INCLUDING OTHER SIGNIFICANT HEALTH PROBLEMS TO ENSURE APPROPRIATE TESTING CAN BE PERFORMED – INCLUDING RELEVANT PMHx AND ONSET/DURATION OF SYMPTOMS

Question to be answered: PLEASE BE AS SPECIFIC AS POSSIBLE. PLEASE INCLUDE ANY OTHER RELEVANT INFORMATION OR TEST RESULTS (MRI OR XRAY REPORTS, PREVIOUS EMG RESULTS IF AVAILABLE)

PROVISIONAL DIAGNOSIS
(please check as appropriate)

- ☐Carpal Tunnel Syndrome
- ☐Ulnar neuropathy
- ☐Brachial plexopathy
- ☐Cervical root - Level _____
- ☐Facial Palsy
- ☐Foot drop
- ☐Lumbosacral plexopathy
- ☐Lumbosacral root - Level_____
- ☐Motor neuron disease
- ☐Myelopathy
- ☐Myopathy
- ☐Neuromuscular Transmission Defect
- ☐Diabetic Peripheral neuropathy
- ☐Other (specify):

Level of Urgency Urgent ☐ Semi Urgent ☐ Routine ☐

Signature of referring provider: Date:

OFFICE USE ONLY	
Date Received:	Notes:

NB: Prior to test, please provide patients with pamphlet about EMG testing – available from EMG clinic or via www.sjhc.london.on.ca/areas-of-care/emg-electromyography-clinic