



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) <table border="0"> <tr> <td>☐ Carpal Tunnel Syndrome</td> <td>☐ Lumbosacral plexopathy</td> <td>☐ Diabetic Peripheral neuropathy</td> </tr> <tr> <td>☐ Ulnar neuropathy</td> <td>☐ Lumbosacral root - Level _____</td> <td>☐ Other (specify):</td> </tr> <tr> <td>☐ Brachial plexopathy</td> <td>☐ Motor neuron disease</td> <td></td> </tr> <tr> <td>☐ Cervical root - Level _____</td> <td>☐ Myelopathy</td> <td></td> </tr> <tr> <td>☐ Facial Palsy</td> <td>☐ Myopathy</td> <td></td> </tr> <tr> <td>☐ Foot drop</td> <td>☐ Neuromuscular Transmission Defect</td> <td></td> </tr> </table>				☐ Carpal Tunnel Syndrome	☐ Lumbosacral plexopathy	☐ Diabetic Peripheral neuropathy	☐ Ulnar neuropathy	☐ Lumbosacral root - Level _____	☐ Other (specify):	☐ Brachial plexopathy	☐ Motor neuron disease		☐ Cervical root - Level _____	☐ Myelopathy		☐ Facial Palsy	☐ Myopathy		☐ Foot drop	☐ Neuromuscular Transmission Defect	
☐ Carpal Tunnel Syndrome	☐ Lumbosacral plexopathy	☐ Diabetic Peripheral neuropathy																			
☐ Ulnar neuropathy	☐ Lumbosacral root - Level _____	☐ Other (specify):																			
☐ Brachial plexopathy	☐ Motor neuron disease																				
☐ Cervical root - Level _____	☐ Myelopathy																				
☐ Facial Palsy	☐ Myopathy																				
☐ Foot drop	☐ Neuromuscular Transmission Defect																				
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