

REQUISITION

ROUTINE URGENT

FOR ELECTRODIAGNOSTIC (EMG) CONSULTATION

REFERRING PHYSICIAN

BILLING#

OFFICE ADDRESS

PHONE #

FAX #

DATE OF REFERRAL

COPIES TO

PATIENT INFO

FIRST NAME

LAST NAME

MIDDLE NAME

M F

PATIENT PHN

D.O.B. DD/MM/YY

PHONE NUMBER

EMAIL ADDRESS

SYMPTOMS

- NUMBNESS/TINGLING
- WEAKNESS
- BURNING PAIN
- MUSCLE ATROPHY
- ELEVATED CREATININE KINASE (CK)
- CRAMPS/FASCICULATIONS
- MYALGIA
- FATIGUE
- DYSPHAGIA
- OTHER:

POSSIBLE DIAGNOSES

- CARPAL TUNNEL SYNDROME/MEDIAN NEUROPATHY
- CUBITAL TUNNEL SYNDROME/ ULNAR NEUROPATHY
- RADIAL NEUROPATHY
- PERIPHERAL NEUROPATHY
- CERVICAL RADICULOPATHY (LEVEL: _____)
- LUMBAR RADICULOPATHY (LEVEL: _____)
- PERONEAL NEUROPATHY
- MOTOR NEURON DISEASE/ALS
- MYASTHENIA GRAVIS
- MYOPATHY
- OTHER:

HISTORY + CLINICAL FINDINGS

EMG CLINIC
YOUR NERVE SPECIALISTS

Dr. C. Preet Chahal, FRCPC

Dr. Harina Chahal, FRCPC

ADULT NEUROLOGY +
NEUROMUSCULAR MEDICINE

REFERRAL FAX
604 553 7001

(APPOINTMENT NOTIFICATION
WILL BE FAXED BACK)

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