Catalyst for Health Medical Clinic

Electrodiagnostic Medicine/Physical Medicine and Rehabilitation

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EMG Referral

Patient Information

Name: _____
DOB: _____
Gender: _____
PHN: _____
Address: _____
Phone: primary _____
alternate_____
Email: _____

Referring Physician

Name: _____
Address: _____
_____
Phone: _____
Fax: _____
Prac ID: _____

WCB Claim No. _____
Date of Accident _____

Case Worker Name:_____
Phone: _____

CLINICAL QUESTION:

	R	*L*	*Both*
Carpal Tunnel Syndrome	❑	❑	❑
Ulnar Neuropathy	❑	❑	❑
Cervical Radiculopathy	❑	❑	❑
Lumbosacral Radiculopathy	❑	❑	❑
Brachial/Lumbar Plexopathy	❑	❑	❑

❑ Polyneuropathy
❑ Myopathy
❑ Neuromuscular Junction Defect

DOES THIS PATIENT HAVE A HISTORY OF:

Diabetes /Metabolic Syndrome	❑ Yes	❑ No
Thyroid Disease	❑ Yes	❑ No
Renal Failure	❑ Yes	❑ No
Connective Tissue Disease (R.A. etc)	❑ Yes	❑ No
Ethanol Abuse	❑ Yes	❑ No
Bleeding Disorder	❑ Yes	❑ No
Anticoagulant Therapy	❑ Yes	❑ No

Is this referral ***URGENT*** ❑ Yes ❑ No

CLINICAL INFORMATION AND REASON FOR REFERRAL: *(Please include relevant previous EMG Studies, MRI's, X-rays, Blood Work, Medication List)****

Physician's Signature:

Date: