Lakeridge Health

Outpatient Nerve Conduction & EMG REFERRAL

Patient's Name:_____

DOB:_____ Gender:☐ M ☐ F

Health Card # _____

Address: _____

Phone number:_____

(Label if appropriate and has all information)

****For Inpatients, consult Neurology On Call first****

Specialty requested:

☐ Neurology ☐ Physiatry ☐ First available (NO PREFERENCE)

Mode of Transport:

☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance Transfer (requires attendee from patient's hospital)

Date of Referral: _____

Referring Physician: _____

CPSO#_____ OHIP Billing # _____ (residents use attending physician #)

Signature of Referring Physician: _____ **Physician stamp for signature**

☐ **CONSULT & ELECTRONIC STUDIES** ☐ **ELECTRODIAGNOSTIC STUDIES ONLY**

REASON FOR REFERRAL − POSITIVE CLINICAL FINDINGS, PERTINENT HISTORY:

_____

_____

e.g. tingling, numbness, wrist/arm pain, foot drop, wrist drop **(please specify which limbs or body area affected)**

Query Specific Diagnosis

Carpal Tunnel Syndrome	☐ R	☐ L	☐ Both
Cubital Tunnel/Ulnar Neuropathy	☐ R	☐ L	☐ Both
Other (eg. Radial, Peroneal) Plexopathy	☐ R	☐ L	☐ Both
Cervical Radiculopathy	☐ R	☐ L	☐ Both
Lumbosacral Radiculopathy	☐ R	☐ L	☐ Both
Polyneuropathy	☐		

Other _____ **MD to review referral:**

PERTINENT LAB/IMAGING FINDINGS:

Please include relevant imaging and lab work (e.g. MRI, CT Scan, Plain film) **attached** ☐ Y ☐ N

If not available, please indicate reason unavailable:

☐ MRI contraindicated _____

☐ MRI pending Booked date: _____ Location: _____

Other (specify) _____

Check all that apply:

Is the patient on anticoagulants or have a bleeding disorder? ☐ Y ☐ N

Does the patient have significant peripheral edema? ☐ Y ☐ N **If yes, MD to review referral**

Please FAX completed form to 905−440−7562
To call for bookings, please PHONE 905−576−8711 extension 33865