# EMG and Consultation Requisition

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Patient's name: Gender: M☐ F☐
DOB: Phone:
Address:
Health Card:
Previous EMG Study: Yes☐ No☐ (If yes, please provide a copy)

Requested Study:

- ☐ Routine EMG
- ☐ Complex EMG (Myasthenia Gravis, Myopathy, Inflammatory Neuropathies, ALS)
- ☐ Single Fibre EMG

A consultation is recommended. Please check this box if consultation is **NOT** required ☐

Reason for Referral (Required): _____

_____

Duration of Symptoms (Required): _____

Past Medical History: _____

_____

_____

Is patient diabetic? Yes ☐ No ☐
Is patient on an anticoagulant? Yes ☐ No ☐

Preferred Consultant:
No Preference☐
Specific Consultant:

Is interpretation required? Yes ☐ No ☐ Language:

Additional Comments: _____

| Date | Physician Name & Billing Number | Signature |
|---|---|---|