EMG REQUISITION

ELECTROMYOGRAPHY

Joseph Brant Hospital
Medical Diagnostic Unit
Phone: 905-336-4126 ◆ Fax: 905-681-4805

APPOINTMENT DATE: _____ **TIME:** _____

Referring Physician: _____

Send Copies To: _____

Patient Name: _____

Address: _____

City: _____ Postal Code: _____

D.O.B: _____
DD MM YYYY

Home Phone: _____ Mobile Phone: _____

Health #: _____ VERSION: _____

☐ **OUTPATIENT**

☐ **INPATIENT**

PHYSICIAN TO COMPLETE ALL DETAILS

PLEASE CHECK REQUIRED TEST

EMG WITH CONSULTATION ☐

EMG ONLY* ☐

***Select only if detailed clinical history and physical exam findings are included in the referral, or if the patient has already had a neurological assessment and the report is attached to this requisition.**

Reason for Referral: _____

Summary of History and Physical Examination Findings: _____

Past Medical History and Medications: _____

Patient Anticoagulated **Yes:** ☐ **No:** ☐

Previous EMG Test: **Yes:** ☐ **No:** ☐ **Where:** _____

Please attach relevant bloodwork, imaging, and/or prior consultation notes.
Patients are asked to avoid applying creams or lotions to the skin on the day of the test.

Physician's Signature _____ Billing Number _____ Date _____