

# NIAGARA NEUROMUSCULAR DIAGNOSTICS

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## ELECTROMYOGRAPHY (EMG) CONSULTATION REQUEST

### PATIENT DEMOGRAPHICS

Last Name	First Name	Date of Birth	HIN	Ver	Sex
Email	Phone	Alt Phone			
Address	City	Prov	Postal Code		

### REFERRING PHYSICIAN

Physician Name	Address	Billing #	Phone	Fax
Copy To (Name/Fax)	Date of Referral	Urgency	Specialty	

### WORKING DIAGNOSIS & MEDICAL HISTORY

WORKING DIAGNOSIS	R	L
Carpal Tunnel Syndrome		
Ulnar Neuropathy		
Cervical Radiculopathy		
Brachial Plexopathy		
Radial Neuropathy (wrist drop)		
Lumbar Radiculopathy		
Lumbosacral Plexopathy		
Peroneal Neuropathy (foot drop)		
Polyneuropathy		
Myopathy		
Neuromuscular Junction Disorder		
Motor Neuron Disease		
Other (specify below)		

MEDICAL HISTORY	Y	N
Diabetes		
Thyroid Disease		
Kidney Disease		
Autoimmune Disease		
Alcohol Use Disorder		
Bleeding Disorder		
Anticoagulant Therapy		
Liver Disease		
Hypertension		
Heart Disease / MI		
Stroke		
COPD		
Depression / Anxiety		

### RELEVANT HISTORY, PHYSICAL FINDINGS, AND INVESTIGATIONS

**SAFETY:** Indicate if patient has PACEMAKER/ICD, is on ANTICOAGULATION, or has a BLEEDING DISORDER (see Medical History)

Signature

Date

Print Name