HealthPointe at CAO BY NEUPATH

EMG REFERRAL FORM

Referring Clinic Information:
Clinician Name:
Address:
City/Postal code:
Phone Number
Fax Number
PRACID:
Email:

Patient Information:
Patient Name:
Date of Birth:
AHC#:
Address:
City/Postal code:
Phone Number:
Email:

Suspected Diagnosis:

- ☐ Carpal Tunnel Syndrome
- ☐ Cervical Radiculopathy
- ☐ Brachial or L/S Plexopathy
- ☐ Other_____
- ☐ Ulnar Neuropathy
- ☐ Lumbosacral Radiculopathy
- ☐ Polyneuropathy

Clinical Question:

Pertinent History and Physical Examination:

Previous EMG:
Date:_____ Where:_____

Anticoagulant therapy or Bleeding disorder? Y☐ N☐ INR:_____ Platelets:_____

Infection: ☐ HIV ☐ Hepatitis B or C

Referral Physician Signature: _____ Date: _____
Print Name: _____

Suite 205, 4309 52 Avenue Red Deer, AB
FAX REFERRALS TO 403.341.6990 CALL 403.309.2001
neupath.com