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REQUISTION FOR NEUROPHYSIOLOGIC (EMG/NCV) TESTING

Date of Request__________________

Patient Name: _________________________ DOB: _____________ Patient Phone: ________________________

Is the patient anticoagulated? **Yes/ No** Is the patient diabetic**? Yes / No**

Referring Doctor________________________ Phone Number______________Fax Number___________________

Diagnosis	Left	Right
Carpal Tunnel Syndrome		
Ulnar Neuropathy		
Radial Neuropathy		
Cervical Radiculopathy		
Brachial Neuritis		
Neck pain		
Peroneal Neuropathy/Foot Drop		
Lumbar Radiculopathy		
Peripheral Neuropathy		
Spinal Stenosis		
Low Back Pain		
Tarsal Tunnel Syndrome		
Peripheral Neuropathy		
Myopathy/Myasthenia/Fatigue		
Guillain Barre		
ALS		

Clinical Information: ____
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Please provide any notes, prior studies and/or MR's if available. For URGENT studies please call the office directly.