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REQUISTION FOR NEUROPHYSIOLOGIC (EMG/NCV) TESTING

Date of Request_____
Patient Name: _____ DOB: _____ Patient Phone: _____
Insurance Plan:_____ Subscriber/Member ID#_____

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: _____
_____

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