

Place patient label here



## EMG Referral Form

**Patient** Name:..... Address:.....  
MR # .....  
Phone: (.....).....

**Referring Provider:**.....Phone.....  
E-mail address: .....FAX #:.....

### **Complaint/History**

- Numbness/Paresthesias/Tingling
- Pain
- Weakness/Fatigue
- increased CK, possible myopathy
- Other – describe below:

### **Duration of Symptoms**

- <4 weeks (it takes >3 weeks to fully develop EMG abnormalities after nerve injury; schedule EMG on appropriate date, otherwise, repeat EMG may be necessary)
- >4 weeks
- >3 months
- >6 months
- >1 year

### **Extremity Affected**

- Arm
- Leg
- Face, Tongue
- Diaphragm/Trunk/Abdomen

### **Side**

- Right
- Left
- Right + Left

### **Evaluate for:**

- Carpal Tunnel Syndrome
- Cervical Radiculopathy
- Lumbar Radiculopathy
- Generalized Peripheral Neuropathy
- Ulnar Neuropathy
- Myopathy
- Brachial Plexopathy
- Myasthenia Gravis/Lambert Eaton Syndrome
- Other – describe below:

**Patient:**  on Warfarin/Heparin  Platelets <30.000  Latex Allergy

### **Previous EMG**

- Yes When?.....Reason?.....
- No

### **EMG Report**

- to Referring Provider
- to other Provider (Name / Phone / FAX# / E-mail).....
- needed by (date): .....

**Fax to Specialty Clinic 275-8260 Fax to HIM 275-3362**  
**(Appointment staff will contact patient to schedule the appointment)**