



London Health Sciences Centre

ELECTROMYOGRAPHY AND NERVE CONDUCTION STUDIES

Telephone: 519-663-3665

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APPOINTMENT: _____
YYYY/MM/DD TIME

WSIB Claim #: _____

IF THIS PATIENT HAS NOT ALREADY BEEN SEEN BY A NEUROLOGIST, WOULD YOU LIKE A NEUROLOGICAL CONSULTATION BOOKED AT THE TIME OF TESTING? Yes No
(Must be requested at time of Booking)

***Consult advised for the conditions indicated below.**

KNOWN CONTACT PRECAUTIONS (eg. Hep B/C, HIV, MRSA, C.Diff.)
 Yes No Describe: _____

INCREASED RISK OF BLEEDING
 Yes No Describe: _____

PROVISIONAL DIAGNOSIS:
 (Please check as appropriate)

- Carpal tunnel syndrome R L
- Ulnar neuropathy R L
- Brachial plexopathy*
- Cervical root Level? _____
- Facial palsy
- Foot drop*
- Lumbosacral plexopathy*
- Lumbosacral root Level? _____
- Motor neuron disease*
- Myelopathy (spinal cord)
- Myopathy*
- Neuromuscular transmission defect eg. myasthenia gravis*
- Peripheral neuropathy
- Other (specify):** _____

ADDITIONAL TESTING REQUESTED:
 (The ultimate choice of studies will be decided on by the EMG Physician.)

- Blink reflex
- Central/proximal motor conduction studies
- SSEPs (Somatosensory Evoked Potentials)
- Respiratory studies
- Other (specify):** _____

WEBSITE:

www.lhsc.on.ca/Health_Professionals/EMG_Lab/

PLEASE PROVIDE SUFFICIENT CLINICAL INFORMATION SO THAT APPROPRIATE TESTING CAN BE PERFORMED.
 If you require further clinical input to guide studies for complex cases and/or to arrange for further investigations or therapy, a consultation should be requested in addition to EMG/NCS testing (see check box above).

ORIGINAL REPORT WILL BE SENT TO REFERRING PHYSICIAN

Referring Physician: _____ Family Physician: _____
 Signature of Referring Physician: _____ Other: _____

NB: prior to test, please provide patients with pamphlet about EMG testing which is available from the EMG laboratory.