

**EMG/NCV Clinic Neurology**  
Fax: 504.903.1605

Patient Label/Stamp

Referral from:  BMC  EKL  LJC  LAK  
 LIH  UMC  WOM  Other: \_\_\_\_\_

Attending Provider: \_\_\_\_\_ ID Number: \_\_\_\_\_

*If Label /Stamp is Not Available Complete the Following:*

Patient's Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Medical Record#: \_\_\_\_\_

1° Contact Number: \_\_\_\_\_ 2° Contact Number: \_\_\_\_\_

Email: \_\_\_\_\_

Reason for referral:

Peripheral Neuropathies:

250.6 Diabetic Neuropathy

Entrapment Neuropathies:

354.0 Carpal Tunnel Syndrome

354.2 Ulnar Nerve Entrapment

355.5 Tarsal Tunnel Syndrome

Suspected Neuropathic Conditions:

729.5 Pain in Limb

729.2 Radiculopathy

EMG EXTREMITIES TO BE TESTED:

Left Lower

Right Lower

Left Upper

Right Upper

Clinical History Relevant for this Referral: \_\_\_\_\_

Is this patient Diabetic?  YES  No

Is this patient Anti-coagulated?  Yes  No

Risk of Communicable disease?  Yes  No

Referring Provider's Signature: \_\_\_\_\_ ID Number: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Referring Service/Clinic: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

OFFICE USE ONLY: Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_:\_\_ am/pm.

If not scheduled, Indicate Reason & Recommendation: \_\_\_\_\_

Reviewing Provider's Signature: \_\_\_\_\_ ID Number: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Rev 02/19/09