

Patient Label

**EMG/NCV Clinic Physiatry**

**Fax: 504.903.1605**

**From:**  BMC  EKL  LJC  LAK  ILH  UMC  WOM  Other: \_\_\_\_\_

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

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

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

Mailing Address: \_\_\_\_\_

1° Contact Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ 2° Contact Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

**Indicate reason for referral:**

Entrapment Neuropathies:

354.0 Carpal Tunnel Syndrome

354.2 Ulnar Nerve Entrapment

355.5 Tarsal Tunnel Syndrome

Myopathies:

359.9 Myopathy, unspecified

359.5 Myopathy, endocrine

Nerve Injuries:

355.0 Sciatic Nerve Lesion

354.3 Radial Neuropathy

355.1 Meralgia paresthetica

353.1 Lumbosacral Plexus Lesion

355.3 Peroneal Neuropathy

353.0 Brachial Plexus Lesions

Neuromuscular Junction Disorders:

358.0 Myasthenia gravis

Suspected Neuropathic Conditions:

729.5 Pain in Limb

729.2 Radiculopathy

Peripheral Neuropathies:

356.1 Charcot-Marie-Tooth Disease

357.81 C. I. D. P.

250.6 Diabetic Neuropathy

351.9 Facial Nerve Disorder

357.0 Guillain-Barre Syndrome

354.5 Mononeuropathy Multiplex

335.29 Motor Neuron Disease

357.9 Unspecified Polyneuropathy

**EMG Extremities to be tested:**

Left Lower

Left Upper

Right Lower

Right Upper

**Evoked Potentials:**

SSEP Upper

SSEP Lower

Neuromuscular Junction Testing

**Is this patient Diabetic?**

Yes

No

**Is this patient Anti-coagulated?**

Yes

No

**Risk of Communicable disease?**

Yes

No

**If the study is positive for carpal tunnel syndrome are you requesting a steroid injection be administered?**

Yes

No

**Clinical History Relevant to this Referral:** \_\_\_\_\_

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

**Contact No.:** (\_\_\_\_) \_\_\_\_\_ **Referring Service/Clinic:** \_\_\_\_\_

**Fax No.:** (\_\_\_\_) \_\_\_\_\_ **Email:** \_\_\_\_\_

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

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

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

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

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