EMG LONDON

4520 Colonel Talbot Road
London, Ontario N6P 1B6

Bus: (519) 652-2141 (Ext 23)
Fax: (519) 652-2138

❑ URGENT

ELECTRODIAGNOSTIC REQUISITION

Surname:_____

Given Names:_____

Address:_____

City:_____ Postal Code:_____

OHIP No._____ VC:_____

Phone:_____ Date of Birth MM/DD/YYYY

Gender: M ❑ F ❑ UK ❑

WSIB No._____ MVA: Y or N

Date of Injury: _____

Referring Physician: _____

Address: _____

City:_____ Postal Code:_____

Phone:_____ Fax:_____

Referring Physician Billing No.:_____

Family Physician: _____

Stamp

Check if Applicable: Hepatitis ❑ HIV/Aids ❑ Prior EMG ❑

Reason(s) for referral: EMG + Injections

Carpal Tunnel Syndrome	R ❑	L ❑
Ulnar Entrapment	R ❑	L ❑
Meralgia Paresthetica	R ❑	L ❑
Cervical Radiculopathy	R ❑	L ❑
Lumbosacral Radiculopathy	R ❑	L ❑
Foot Drop	R ❑	L ❑
Peripheral Neuropathy (Upper)	R ❑	L ❑
Peripheral Neuropathy (Lower)	R ❑	L ❑

Other Conditions: _____

ADDITIONAL INJECTIONS REQUESTED ❑

For Conditions identified by you or the EMG Physician: (e.g.Trigger Finger, CMC Joint OA, De Quervain's, Trigger Points, MCP, Tendonitis, etc.)

Other:

Other Notes/Symptoms:

Please provide copies of any relevant tests (EMG, CT Scan, MRI, etc.)

_____ Authorized Signature

_____ Date