EMG/Consult Requisition – Dr. J. L. Steckley

Stratford General Hospital - HPHA
46 General Hospital Drive
Stratford, ON N5A 2Y6

Phone: 519-272-8210 ext. 2415
Fax: 519-272-8201

Patient Name: _____
Address: _____
Telephone: _____
DOB: _____
Sex: _____
HC number: _____

Referral Question: (please send patient profile, medications and relevant laboratory testing/imaging results)

ARM(S)
☐ median neuropathy / carpal tunnel syndrome
☐ ulnar neuropathy
☐ radial neuropathy
☐ other focal neuropathy_____
☐ cervical radiculopathy
☐ brachial plexopathy

Date _____
Referring Physician _____
Address _____
_____
Phone: _____
Fax: _____

LEG(S)
☐ polyneuropathy
☐ peroneal neuropathy
☐ other focal neuropathy_____
☐ lumbosacral radiculopathy
☐ lumbosacral plexopathy

DIFFUSE WEAKNESS
☐ myopathy (must include CK)
☐ myasthenia (consider acetylcholine rec antibodies)
☐ ALS / motor neuron disease
(include CK, MRI C and LS spine)

FACE
☐ trigeminal neuropathy
☐ Bell's palsy / facial neuropathy

☐ **OTHER** _____

Select one of the following options: (EMG and consult includes neurologic consultation, appropriate EMG testing, recommendations for investigation and management, and may include follow-up assessments as appropriate)

☐ EMG and Consult – please outline clinical problem below
_____
_____
_____
_____
_____

☐ EMG only – please specify which muscles, nerve roots and nerves to study
_____
_____

Referring Physician Signature: _____ **Family Physician:** _____
Billing Number: _____ **Appointment Date & Time:** _____