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NERVE CONDUCTION STUDY/EMG REFERRAL

NOTE: If a neurology consultation is required, please do not complete this form. Consultation referrals should be directed to our clinic on Fax/Email.

Patient name:	**Phone:**
Address:	**Email:**
	Date of birth:

REASON FOR REFERRAL (e.g., carpal tunnel syndrome, peripheral neuropathy):

RELEVANT CLINICAL FINDINGS (e.g., wasting/weakness, diabetes mellitus):

Is the patient on anticoagulation?	☐ **Y**	☐ **N**	
Does the patient have a latex allergy?	☐ **Y**	☐ **N**	
Previous NCS performed?	☐ **Y**	☐ **N**	**If 'Y', please attach results**

REFERRING DOCTOR

Name:	**Fax:**
Provider no:	**Telephone:**
Clinic/Address:	**Signature:**
Email:	**Date:** **Copies to:**