London Health Sciences Centre

ELECTROMYOGRAPHY AND NERVE CONDUCTION STUDIES

Telephone: 519-663-3665 Fax: 519-663-3592

APPOINTMENT: _____
YYYY/MM/DD TIME

WSIB Claim #: _____

IF THIS PATIENT HAS NOT ALREADY BEEN SEEN BY A NEUROLOGIST, WOULD YOU LIKE A NEUROLOGICAL CONSULTATION BOOKED AT THE TIME OF TESTING? ☐ **Yes** ☐ **No**
(Must be requested at time of Booking)
***Consult advised for the conditions indicated below.**

KNOWN CONTACT PRECAUTIONS (eg. Hep B/C, HIV, MRSA, C.Diff.)
☐ Yes ☐ No Describe: _____

INCREASED RISK OF BLEEDING
☐ Yes ☐ No Describe: _____

PROVISIONAL DIAGNOSIS:
(Please check as appropriate)

- ☐ Carpal tunnel syndrome ☐ R ☐ L
- ☐ Ulnar neuropathy ☐ R ☐ L
- ☐ Brachial plexopathy*
- ☐ Cervical root Level? _____
- ☐ Facial palsy
- ☐ Foot drop*
- ☐ Lumbosacral plexopathy*
- ☐ Lumbosacral root Level? _____
- ☐ Motor neuron disease*
- ☐ Myelopathy (spinal cord)
- ☐ Myopathy*
- ☐ Neuromuscular transmission defect eg. myasthenia gravis*
- ☐ Peripheral neuropathy
- ☐ **Other (specify):** _____

ADDITIONAL TESTING REQUESTED:
(The ultimate choice of studies will be decided on by the EMG Physician.)

- ☐ Blink reflex
- ☐ Central/proximal motor conduction studies
- ☐ SSEPs (Somatosensory Evoked Potentials)
- ☐ Respiratory studies
- ☐ **Other (specify):** _____

WEBSITE:
www.lhsc.on.ca/Health_Professionals/EMG_Lab/

PLEASE PROVIDE SUFFICIENT CLINICAL INFORMATION SO THAT APPROPRIATE TESTING CAN BE PERFORMED.
If you require further clinical input to guide studies for complex cases and/or to arrange for further investigations or therapy, **a consultation should be requested in addition to EMG/NCS testing** (see check box above).

ORIGINAL REPORT WILL BE SENT TO REFERRING PHYSICIAN

Referring Physician: _____ Family Physician: _____

Signature of Referring Physician: _____ Other: _____

NB: prior to test, please provide patients with pamphlet about EMG testing which is available from the EMG laboratory.