London Health Sciences Centre

Form Date: 2026/01/09

EMG Referral Form

Fax completed form to 519-663-3204

EMG will be booked as a consult with EMG unless they are already under the care of a neurologist.

Patient Information

First Name:

Last Name:

Middle Initial:

Preferred Name:

Address:

City:

Postal Code:

Preferred Phone Number:

Email Address:

Patient consents to appointment information being shared via text message or email:

☐ **Yes (text)** ☐ **Yes (email)**

Date of Birth:

Health Card Number (HIN):

Version Code:

WSIB Claim Number:

Other (Self pay, research or third party):

Sex assigned at birth:

☐ **Female** ☐ **Male**

Interpretor Required:

☐ **Yes** ☐ **No**

Language Required:

Accessibility Needs:

Provisional Diagnosis

- [ ] **Carpal tunnel syndrome**
- [ ] **Ulnar neuropathy**
- [ ] **Brachial plexopathy**
- [ ] **Cervical radiculopathy**

Level:

- [ ] **Lumbosacral radiculopathy**

Level:

- [ ] **Lumbosacral plexopathy**
- [ ] **Foot drop**
- [ ] **Facial palsy**
- [ ] **Motor neuron disease**
- [ ] **Myopathy**
- [ ] **Neuromuscular transmission defect (e.g., myasthenia gravis)**
- [ ] **Peripheral neuropathy**
- [ ] **Other**

Clinical History

Please describe patient presentation including symptoms, timing of onset, and progression

Pertinent neurological examination findings:

Pertinent investigations including imaging (please note location of imaging if done)

Has the patient been seen by a neurologist for the same condition? ☐ **Yes** ☐ **No**

If yes, who?

Is the patient on anticoagulation? ☐ **Yes** ☐ **No**

If yes, describe:

Any known infection control precautions required? ☐ **Yes** ☐ **No**

If yes, describe:

Referring Provider

Provider Name:

Billing Number:

Professional ID:

Address:

City:

Province:

Postal Code:

Phone Number:

Fax Number:

Copy To:

PROVIDER SIGNATURE:

Referral Date: