Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

Hôpital Général de Kingston General Hospital

REQUEST FOR EMG CONSULTATION

ELECTROMYOGRAPHY
EMG REFERRAL

Department of Neurology
Connell 7
Fax: 613-548-1388

Dr. Michel Melanson
Phone: 613-549-6666 x 2601

PATIENT INFORMATION CR#: _____

SURNAME _____ First Name _____

Date of Birth (YYYY/MM/DD) _____ ☐ MALE ☐ FEMALE

Health OHIP#: _____ Version_____

Address_____

City _____ Postal Code _____

Home #: _____ Work#:_____ Cell #: _____

Previous EMG: (Y / N) **Location:** _____ **Date:**_____
YYYY/MM/DD

Referring Physician Information *Please provide full name and Sign Requisition*

DR: _____ OHIP Billing #: _____

Phone # _____ FAX # _____

Physician's Signature _____ Date Requested: _____
YYYY/MM/DD

Please indicate:

- ☐ EMG/Nerve conduction Study
- ☐ Carpal Tunnel test (at PCH)
- ☐ Multiple nerves/limbs
- ☐ Brainstem Reflexes
- ☐ Neuromuscular transmission
- ☐ Quantitative EMG
- ☐ Single fibre EMG

Patient History: _____

_____

Neurological Signs: _____

_____

Provisional Diagnosis: _____

Indications for Test: _____

Medications: _____

_____

OFFICE USE:
EMG physician: Melanson / Other _____

Clinic Date (YYYY/MM/DD) _____ Time hhmm _____