EMG REFERRAL ONLY FORM

SEMMES MURPHEY
Leaders in Brain & Spine Care

DATE:		CONTACT:	
FAX:	833.449.3605	REFERRING MD:	
PHONE:	901.522.7700	PHONE:	FAX:
		ADDRESS:	

Patient Name: _____ DOB: _____ PHONE: _____

Address_____

Insurance:_____ ID:_____

Requested test:

[ ] Bilateral Upper Extremities EMG/NCS	[ ] Bilateral Lower Extremities EMG/NCS
[ ] Left Upper Extremity EMG/NCS	[ ] Left Lower Extremity EMG/NCS
[ ] Right Upper Extremity EMG/NCS	[ ] Right Lower Extremity EMG/NCS

Please note we cannot perform testing on bilateral upper and lower extremities on the same day

Reason for EMG/NCS referral:

[ ] Carpal Tunnel Syndrome	[ ] Ulnar/Radial Nerve
[ ] Paresthesia (Numbness/Tingling)	[ ] Diabetic Neuropathy
[ ] Peripheral Neuropathy	[ ] Myopathy
[ ] Radiculopathy	[ ] Sciatica
[ ]Other Diagnosis/Symptoms:	[ ] R/O Neuromuscular Issue: Please Specify Below
_____	_____

Is Patient Diabetic: [ ] Yes [ ] No Type: 1 or 2 How Long:_____

Is the Patient Currently on Anticoagulation: [ ] Yes [ ] No

If yes, Which Medication: _____

Please attach a demographic sheet, copy of health insurance card (carrier/ID), treatment notes and imaging reports.

Date: _____ Physician Name: _____ Physician Signature: _____