

EMG REFERRAL ONLY FORM



SEMME 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:

<input type="checkbox"/> Bilateral Upper Extremities EMG/NCS	<input type="checkbox"/> Bilateral Lower Extremities EMG/NCS
<input type="checkbox"/> Left Upper Extremity EMG/NCS	<input type="checkbox"/> Left Lower Extremity EMG/NCS
<input type="checkbox"/> Right Upper Extremity EMG/NCS	<input type="checkbox"/> 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:

<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Ulnar/Radial Nerve
<input type="checkbox"/> Paresthesia (Numbness/Tingling)	<input type="checkbox"/> Diabetic Neuropathy
<input type="checkbox"/> Peripheral Neuropathy	<input type="checkbox"/> Myopathy
<input type="checkbox"/> Radiculopathy	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Other Diagnosis/Symptoms: _____	<input type="checkbox"/> R/O Neuromuscular Issue: Please Specify Below _____

Is Patient Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: <u> 1 or 2 </u> How Long: _____
Is the Patient Currently on Anticoagulation: <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

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