BRANT COMMUNITY HEALTHCARE SYSTEM

ELECTROMYOGRAM (EMG) REQUISITION

200 Terrace Hill St., Brantford ON N3R 1G9
Tel: 519-751-5599 Fax: 519-751-5813

For Office Use Only:
Appointment Date/Time:

REFERRING CLINICIAN INFORMATION		PATIENT INFORMATION	
Name:		Health Card / Version / DOB (D D M M Y Y Y Y) / Sex (M F U)	
OHIP Billing Number:		First Name:	Last Name:
Address		Address:	
City/Prov:	Postal Code:	City/Province:	Postal Code:
Phone:	Fax:	Phone Number:	Secondary Phone Number:
Signature:		WSIB Claim #:	Secondary Insurance:
Copies to:		Patient Height:	Patient Weight:

Does Patient Require Assistance? ☐Mechanical Lift ☐ Wheelchair ☐Language Interpreter - Specify:

EXAM REQUESTED (BY APPOINTMENT ONLY) **INCOMPLETE REQUISITIONS WILL BE RETURNED**

☐EMG and Nerve Conduction Study with Partial Consultation pertaining to the problem ☐Upper Body ☐Lower Body
☐EMG and Nerve Conduction Study with Full Consultation ☐Upper Body ☐Lower Body
☐EMG and Nerve Conduction Study ☐Upper Body ☐Lower Body

CLINICAL HISTORY: REASON FOR ORDER

QUESTION YOU WOULD LIKE ANSWERED BY THIS EXAM:

Related Previous Imaging and Labs: ☐Yes ☐No If yes, please attach previous if not completed at BGH.

Please include all relevant patient history including previous reports or consult notes as appropriate.