First Name	Last Name
Date of Birth *(yyyy-Mon-dd)*	Personal Health Number
Address	
Postal Code	Hospital ID Number
Home Phone Number	Alternate Phone Number

EMG/Nerve Conduction Consultation Request (Calgary Zone)

Important:

- Please **attach all** appropriate Consultation Notes and investigations
- This form must be filled out completely before an appointment will be booked. A letter with appointment details will be mailed to the patient and also faxed to the Referring Physician
- The patient is required to confirm the appointment 7 days before or it will be cancelled
- If Name of requested physician and site is not indicated, patient will receive earliest appointment at any site
- For booking **fax** to 403.219.0967 and **call** 403.943.5462 for inquiries or confirmation

Name of Requested Physician	Site Requested	
Name of Referring Physician	Phone Number	Fax Number
Name of Physician to Receive Copies	Phone Number	Fax Number

WCB *(Workers' Compensation Board)* Case

☐ No ☐ Yes, WCB Number ________________________

Clinical Question

☐ Carpal Tunnel Syndrome	☐ Ulnar Neuropathy	☐ Brachial Plexopathy
☐ Cervical Radiculopathy	☐ Peroneal Neuropathy	☐ Lumbosacral Plexopathy
☐ Lumbosacral Radiculopathy	☐ Polyneuropathy	☐ Myopathy

☐ Other ____

If you feel this Patient requires an **urgent EMG**, you must indicate why. Reasons for urgent may include, Severe sensory and/or motor dysfunction causing significant functional impairment. Pain causing functional impairment will not result in an urgent triage status. If this section is not completed, the referral will not be triaged as urgent."

____

____

Relevant History and Physical

____

____

____

____

____

____

____

____

____

____

Referring Physician Signature	Date *(yyyy-Mon-dd)*