SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Neurology Laboratories

Health Record #: ______________________ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* ______________________
DOB: dd / mm / yy   Age: ______   ❑ Female ❑ Male
OHIP #: ______________   Version Code: ______________
Account #: ______________   Date of Admission: dd / mm / yy

TO BOOK AN APPOINTMENT FAX COMPLETED REQUISITIONS TO (905) 853-2211

Electromyography (EMG) / Nerve Conduction (NCS) Requisition

❑ OUT-PATIENT ❑ IN-PATIENT

Patient Name: *(print first, last)*		**Appointment Date:** dd / mm / yy
Address: Street Number + Name	Apartment	**Appointment Time:**
City Province	Postal Code	**Arrival Time:**
Health Card Number:	**Version Code:**	**Hospital Record #:**
Other Insurance:	**WSIB Number:**	**Date of Birth:** dd / mm / yy
Home: ( )	**Work/Other:** ( )	**Patient Weight:** ______ kg

❑ Routine EMG/NCS and consultation
❑ Complex EMG/NCS (Please select for neuromuscular junction disorders, motor neuron disease, or myopathy assessment)

Symptoms (please provide information re: symptom, side and site):

(i) Symptom/sign	(ii) Side	(iii) Site	
❑ Tingling, numbness	❑ Right	❑ Neck/shoulder	❑ Back/hip
❑ Pain	❑ Left	❑ Arm	❑ Leg
❑ Weakness	❑ Bilateral	❑ Hand	❑ Foot

Diagnosis to assess (check one or more, write in details):

Upper Limb	Lower Limb	Generalized Condition
❑ Carpal Tunnel Syndrome	❑ Peroneal Neuropathy	❑ Peripheral Neuropathy
❑ Ulnar Neuropathy	❑ Tibial Neuropathy	❑ Motor Neuron Disease
❑ Radial Neuropathy	❑ Sciatic Neuropathy	❑ Myopathy
❑ Brachial Plexopathy	❑ Lumbosacral Plexopathy	❑ Neuromuscular junction disorder (e.g. myasthenia gravis)
❑ Cervical Radiculopathy	❑ Lumbar Radiculopathy	

Reason for Referral:

❑ Relevant Consultation Notes
❑ Relevant Recent Bloodwork
❑ Prior Imaging (MRI, CT)

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Physician Information:

Referring Physician: *(print first, last)*			**Date:** dd / mm / yy
Signature:	**CPSO #**	**Billing #**	**Office Phone:** ( )
Address:			**Fax Number:** ( )

Family Physician same as above ❑ **Yes** ❑ **No** **If no, please provide information below**

Family Physician: *(print first, last)*	**Office Phone:** ( )
Address:	**Fax Number:** ( )

IMPORTANT INFORMATION FOR EMG PATIENTS

- Please arrive 20 minutes before your test. Late arrivals may result in losing your appointment.
- Please bring your Health Card, this requisition and any other pertaining documents.
- Please ensure skin is clean and dry without lotions, oils, or creams.
- Please wear loose, comfortable clothing (please wear short sleeves and shorts to allow easy access).
- Please bring a list of your current medications. You may take your medication as usual.
- Wear warm gloves and socks on cool days as having cold hands or feet can affect the test.

NOTE: You will be undergoing a test using electrical stimulation of nerves and a recording needle in some muscles to diagnose your condition.

SL2729_03 (05/24) "Neurology Laboratories" Review (05/27)