SouthlakeHealth

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

# *Electromyography (EMG) / Nerve Conduction (NCS) Requisition*

☐ OUT-PATIENT ☐ IN-PATIENT

***Please fax to (905) 853-2111***

| | | |
|---|---|---|
| **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)

## TO BOOK AN APPOINTMENT FAX COMPLETED REQUISITIONS TO (905) 853-2111

**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)*

| | |
|---|---|
| **Address:** | **Office Phone:** ( ) |
| | **Fax Number:** ( ) |



SL2729_05 (11/24) "Neurology Laboratories" Review (11/27)

SouthlakeHealth
Leading Edge Care. Close to Home.

596 Davis Drive
Newmarket, ON L3Y 2P9
T: 905-895-4521
F: 905-853-2111
**southlake.ca**

**Neurology Laboratories**

# *Electromyography (EMG) / Nerve Conduction (NCS) Requisition Patient Preparation and Information*

## 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.***



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