ACCESS
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# EMG ASSESSMENT FORM

## Referring Clinic Information

**Clinician Name**

**Address**

**City**

**Postal Code**

**Phone Number**

**Fax Number**

**PRACID**

**Email**

## Patient Information

**Patient Name**

**Date of Birth** MM /DD / YYYY

**AHC #**

**Address**

**City**

**Postal Code**

**Phone Number**

**Email**

## Suspected Diagnosis:

- ☐ Carpal Tunnel Syndrome
- ☐ Cervical Radiculopathy
- ☐ Brachial or L/S Plexopathy
- ☐ Other _____
- ☐ Ulnar Neuropathy
- ☐ Lumbosacral Radiculopathy
- ☐ Polyneuropathy

## Reason for EMG Assessment (Please include the area of numbness, tingling, pain, weakness, etc.)

## Relevant History, Physical Examination & Investigation Findings

Anticoagulant therapy or Bleeding disorder? Yes ☐ No ☐ INR: _____ Platelets_____

If yes, state disorder & list medications:

_____

Infection: ☐ HIV ☐ Hepatitis B or C

Defibrillator / Pacemaker: ☐ Yes ☐ No

Referral Physician Signature:_____ Date: _____

Print Name:_____

**If previous EMG tests have been performed, please attach to this consultation**