ABSOLUTE MEDICAL CENTRE
60 Main St. East, Grimsby, Ontario

First Name	Last Name
Date of Birth *(yyyy-Mon-dd)*	OHIP Number
Address	
Postal Code	
Home Phone Number	Cell Phone Number

EMG / Nerve Conduction Consultation Request

- Please **attach all** appropriate Consultation Notes and Investigations.
- This form must be filled out completely before an appointment will be booked.
- The patient is required to confirm the appointment 5 days before or it will be cancelled.
- For booking **FAX** to (289) 235-7451
- **CALL** (289) 235-7700 for inquiries

REFERRING PHYSICIAN INFO:		
Referring Physician Name (incl. Billing Number)	Phone Number	Fax Number
Family Doctor Name (incl. Billing Number)	Phone Number	Fax Number

WSIB *(Workers' Compensation Board) Case:*
☐ No ☐ Yes, WSIB Number _____

Clinical Question:
☐ Carpal Tunnel Syndrome ☐ Ulnar Neuropathy ☐
☐ Cervical Radiculopathy ☐ Peroneal Neuropathy ☐
☐ Lumbosacral Radiculopathy ☐ Peripheral Neuropathy ☐
☐ 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 & Physical Exam Findings:

Relevant Past Medical History: (Diabetes, Thyroid Disease, Cancer treated with Chemotherapy)

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