



SHIRE NEUROLOGY

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Supporting full and healthy lives

Patient Details

Name: _____ DOB: _____

Address: _____ Contact No: _____

NEUROLOGY & NEUROPHYSIOLOGY REQUEST FORM

Services requested: (please tick all relevant)

- ☐ Consultation
☐ Dr Ik Lin Tan ☐ Dr Katie Yin ☐ Dr Justine Wang
- ☐ Nerve Conduction study +/- EMG
- ☐ Repetitive nerve stimulation
- ☐ Carpal tunnel study
- ☐ EEG (adult and pediatric)
- ☐ Botox (chronic migraine, hyperhidrosis, hemifacial spasm, blepharospasm, dystonia)

Clinical Information: _____

Medications: _____

Referring Doctor: _____ Date: _____

Address: _____

Provider no: _____ Telephone: _____ Fax: _____