ELECTROMYOGRAPHY (EMG) Referral Form

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Patient Name: ______________________ **Phone:** ______________________

Diagnosis: ______________________

Pertinent PMHx:		**Extremity affected:**			**Side:**	
□ Numbness/Tingling	□ Increased CK	□ Arm	□ Trunk	□ Abdomen	□ Right	□ Left
□ Pain	□ Weakness/Fatigue	□ Leg	□ Face	□ Other	□ Right + Left	

Duration of Symptoms:		**Evaluate for:**	
□ < 4 weeks	□ > 6 months	□ Carpal tunnel syndrome	□ Ulnar Neuropathy
□ > 4 weeks	□ > 1 year	□ Cervical Radiculopathy	□ Myasthenia Gravis
□ > 3 months	□ > 2 years	□ Lumbar Radiculopathy	Lambert Eaton
		□ Generalized Peripheral Neuropathy	□ Plexopathy

Previous EMG: □ YES □ NO **When?** **Reason?** □ on Warfarin/Heparin

Comments:

Physician Signature: ______________________ **Date:** ______________________

Fax to 209-830-8837 (Appointment staff will contact patient to schedule the appointment)