Interior Health

NERVE CONDUCTION STUDIES (NCS) AND ELECTROMYOGRAPHY (EMG) REFERRAL

Kelowna General Hospital
Dr. Walter Anderson Building

2251 Pandosy Street, Kelowna, B.C. V1Y 1T1 Phone: **(250) 980-1392** Fax: **(250) 862-4463**

Patient Name *(last)* _____

(first) _____

DOB *(dd/mm/yyyy)* _____

PHN _____ MRN _____

Account / Visit # _____

IH USE ONLY

Patient Information

Name _____ Sex ☐ M ☐ F

Date of Birth *(dd/mm/yyyy)* _____ PHN _____

Address _____

Home Phone _____ Work Phone _____ Cell _____

Referral Information

Priority: ☐ Routine ☐ Urgent *(please explain)* _____

Clinical Question

☐ Carpal Tunnel Syndrome
☐ Ulnar Neuropathy
☐ Cervical Radiculopathy
☐ Lumbosacral Radiculopathy
☐ Polyneuropathy
☐ Myopathy
☐ Brachial Plexopathy
☐ Lumbosacral Plexopathy
☐ Myasthenia Gravis
☐ Other _____

Relevant History and Examination: ☐ **Ambulatory** ☐ **Standby Assist** ☐ **Mechanical Lift**
(include any relevant investigations, CK level, imaging studies, consults, prior EMG studies, special care needs, any precautions etc.)

Referring Physician Name _____ MSP _____

WSBC _____ Phone _____ Fax _____

Physician(s) to receive copies of EMG report _____

Date (dd/mm/yyyy)	Time (24 hour)	Referring Physician Signature	Designation / College ID #
/ /			

IH USE ONLY

Date Received (dd/mm/yyyy)	Time Received (24 hour)	Name	Designation
/ /			

Reassigned Priority

Date (dd/mm/yyyy)	Time (24 hour)	Physician Name	College ID #
/ /			

Permanent part of the health record