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## EMG Assessment

### Patient Information

*labels can be used*

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Gender: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Personal Health Number: \_\_\_\_\_

### Referring Clinic Information

*labels and/or stamps can be used*

Clinic Name: \_\_\_\_\_

Referring Physician Name: \_\_\_\_\_

PRACID: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

*(If different than above)*

Family Physician Name: \_\_\_\_\_

PRACID: \_\_\_\_\_

### Suspected Diagnosis:

Carpal Tunnel Syndrome

Cervical Radiculopathy

Brachial or L/S Plexopathy

Other: \_\_\_\_\_

Ulnar Neuropathy

Lumbosacral Radiculopathy

Polyneuropathy

### Reason for Assessment:

*If additional space is needed, please include a separate referral letter. Also include all relevant investigations and/or consultation reports.*

### Symptom Onset:

Anticoagulant therapy or bleeding disorder:

No

Yes

INR: \_\_\_\_\_

Platelets: \_\_\_\_\_

Previous EMG

Date: \_\_\_\_\_

Where: \_\_\_\_\_

WCB Claim Number:

For Kinesis Medical Centre use only

Date Referral Received: \_\_\_\_\_

Review Date: \_\_\_\_\_

Wait List: I II III