Kinesis
Physical Medicine and EMG

Kinesis Medical Centre
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EMG Assessment

Patient Information
labels can be used

Last Name: _____
First Name: _____
Address: _____
City: _____
Province: _____
Postal Code: _____
Email: _____
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: _____
PRAC ID: _____
Address: _____
_____
City: _____
Province: _____
Postal Code: _____
Phone Number: _____
Fax Number: _____
(If different than above)
Family Physician Name: _____
PRAC ID: _____

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.***

WCB Claim Number: _____ **Symptom Onset:** _____

Anticoagulant therapy or bleeding disorder: ☐ No ☐ Yes INR: _____ Platelets: _____

Previous EMG Date: _____ Where: _____
Please enclosed previous EMG reports.