fraserhealth

NEUROLOGY CLINIC REFERRAL NEUROMUSCULAR (INCLUDES EMG)

FAX to JPOCSC Central Intake (604-953-9701)

PATIENT INFORMATION:

Patient's Name: _____ **Gender:** _____
Last First Middle

Date of Birth: _____/_____/_____ **PHN:** _____ **Insurance:** _____
(DD/MM/YYYY)

Address: _____
Street City Province Postal Code

Contact Method Primary: _____ **Alternate:** _____

REFERRAL INFORMATION:

Priority: ☐ **Routine** ☐ **Urgent**

Referring Health Care Provider:
Name: _____
Title: _____ **Source:** _____
MSP #: _____
Phone: _____ **Fax:** _____

Reason for Referral: _____

Medical Reason for Urgency: _____

Relevant Medical History: _____

Isolation precautions ☐ **Airborne** ☐ **Contact** ☐ **Droplet** ☐ **None**

Interpreter Required ☐ **No** ☐ **Yes** **If yes, specify language** _____

Referral Clinic: Neurology - Neuromuscular (EMG)

Referring Health Care Provider Signature: _____ **Date:** _____

☐ **EMG**
- ☐ **Carpal Tunnel Syndrome**
- ☐ **Ulnar Neuropathy**
- ☐ **Peroneal Neuropathy/foot drop**
- ☐ **Polyneuropathy**
- ☐ **Plexopathy**
- ☐ **Radiculopathy**
- ☐ **Other**

If Radiculopathy, please specify Level: _____

If other, please specify: _____

Has this patient been seen by a neurologist previously? ☐ **Yes** ☐ **No** **(if Yes, please attach consult)**
Neurologist seen: _____

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