



fraserhealth

NERVE CONDUCTION STUDY/ELECTROMYOGRAPHY TEST REQUISITION (NCS/EMG) Abbotsford Regional Hospital



MSXX107235A

New: Apr 11/19

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**Please avoid duplicate referrals. Referral to (choose only one):
Fax referral directly to neurologist's office. Incomplete referrals will be returned to sender.**

Dr. A. Bhangav

Phone 604-746-7868
Fax 604-746-7783

Dr. F. Tanha

Phone 604-870-8736
Fax 604-870-8746

Dr. A. Costantino

Phone 604-853-6169
Fax 604-853-1004

Routine Urgent (Please explain) _____

All requests are seen in neurology consultation (with rare exceptions based on neurologist discretion).

Outpatient Inpatient (location) _____ Previous ARHCC EMG Yes No

Patient Surname:	First Name:	Patient Phone #:	Patient Address:
PHN:	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB: dd/mm/yyyy	City, Province: Postal Code:
Is this a WCB claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claim #:	Date of Injury:
Is this an ICBC claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claim #:	Date of MVA:
Ordering Physician's Name:	MSP#:	Telephone #:	Address:
		Fax #:	
Copy to Physician:	MSP#:	Telephone #:	Address:

History and Findings (please mention any physical or cognitive limitations):

Please attach all RELEVANT investigations and consult letters:

Consult letter (specialist) Recent blood work Recent radiology reports

Clinical Diagnosis:

Peripheral Neuropathy

Myopathy

Carpal Tunnel Syndrome

Paresthesia Bilateral Left Right

Bilateral Left Right

Arm(s) Hand(s) Finger(s) Leg(s) Foot / Feet

Ulnar neuropathy

Radiculopathy / Plexopathy

Other _____