EMG ORDER FORM

Please fax this form and medical records to (608) 775-2263

Patient name: _____

Medical record number: _____

Date of birth: _____

Address: _____

Phone: _____

Order date: _____

Ordering provider name: _____

Facility name: _____

Address: _____

Ordering provider phone number: _____ Ordering provider fax number: _____

Ordering provider signature: _____

Location

☐ Arm	☐ Leg	☐ Other (be specific):
☐ Right	☐ Right	_____
☐ Left	☐ Left	_____
☐ Bilateral	☐ Bilateral	_____

Comments:

_____

_____

_____

Is patient taking warfarin (COUMADIN) or dabigatran (PRADAXA)?* ☐ Yes ☐ No

*If yes, only a partial study may be performed.

Will patient require Medi-lift? ☐ Yes ☐ No

To schedule and confirm an appointment:

1. Fax this completed form with medical notes from the order to Neurosciences Schedulers Fax 608-775-2263. The medical record must include the full text of the ordering provider's clinical note about the patient's assessment. The note must document the basis for determining need for an EMG.
2. Please call (800) 362-9567, ext. 59000 or (608) 775-9000 to schedule an appointment.

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