EMG ORDER FORM

Please fax this form and medical records to (608) 775-5263

Patient name: _____ Date of birth: _____ Phone #: _____

MRN: _____ Patient Address: _____

Patient Insurance Information _____

Order date: _____ Ordering provider name: _____

Facility name & address: _____

Ordering provider phone number: _____ Ordering provider fax number _____

Ordering provider signature: _____

1. Approximate onset of symptoms _____ . EMG will be scheduled at minimum 14 – 21 days after symptom onset.

2. Please select your clinical question from below list. Choose best/closest option (may choose more than one if needed). Note that the electromyographer will choose appropriate limbs/studies needed to answer the clinical question.

☐ **Carpal tunnel and/or ulnar neuropathy**

Which side is patient having symptoms? ☐ Right ☐ Left ☐ Bilateral

☐ **Upper limb pain/numbness/weakness of unknown cause** (such as cervical radiculopathy, other upper limb mononeuropathy such as radial, etc.)

Which side is patient having symptoms? ☐ Right ☐ Left ☐ Bilateral

☐ **Suprascapular neuropathy**

Which side is patient having symptoms? ☐ Right ☐ Left ☐ Bilateral

☐ **Brachial plexopathy**

Which side is patient having symptoms? ☐ Right ☐ Left ☐ Bilateral

☐ **Peripheral neuropathy**

☐ Lower limb symptoms only

☐ Both upper and lower limb symptoms

☐ **Lower limb pain/numbness/weakness of unclear cause** (lumbar radiculopathy, lower limb mononeuropathy such as peroneal, tibial, etc.)

Does patient have a known or suspected peripheral neuropathy as well? ☐ Yes ☐ No

Which side is patient having symptoms? ☐ Right ☐ Left ☐ Bilateral

☐ **Lumbosacral plexopathy**

Which side is patient having symptoms? ☐ Right ☐ Left ☐ Bilateral

☐ **Myopathy** ☐ **Neuromuscular junction disorder** ☐ **Motor neuron disease (such as ALS)**

☐ **Pudendal neuropathy/pudendal nerve study** ☐ **Surface EMG for tremor**

☐ **OTHER/NOT LISTED** (describe): _____

Where is patient having symptoms? ☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg

3. Is the patient on anticoagulation? ☐ Yes ☐ No

4. Does the patient have a significant mobility impairment requiring specialized equipment or others for transfers (sit-to-stand, Hoyer lift, etc.)? ☐ Yes ☐ No

To schedule and confirm an appointment:

1. Fax this completed form with medical notes from the order to Neurosciences Schedulers Fax (608) 775-5263. 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.

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