

EMG ORDER FORM

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

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

Right

Left

Bilateral

Leg

Right

Left

Bilateral

Other (be specific):

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) 775-5263.

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 to schedule an appointment.

GUNDERSEN
HEALTH SYSTEM®