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## EMG / NCS REFERRAL FORM

Fax to 800-299-2186

Please include demographics ♦ insurance ♦ relevant notes, imaging, prior NCS/EMG

### Patient Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone number: \_\_\_\_\_

**Study Requested:**  Upper Limb EMG/NCS  Lower Limb EMG/NCS

Electrodiagnostic evaluation may include neuromuscular ultrasound for diagnostic clarity when clinically indicated.

**Priority:**  Routine  STAT / ASAP -- please call or text 817-381-5319 with clinical context

**Clinical Question / Working Diagnosis:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Referring Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**Questions? Call 817-381-5318**