EMG REFERRAL FORM

Office: 203.688.2495
Fax: 203.688.3109

YALE-NEW HAVEN HOSPITAL

❑ HAMDEN

❑ YNHH ❑ SHORELINE MEDICAL CENTER - GUILFORD

PATIENT INFORMATION

PATIENT NAME	YALE MRN	DOB
ADDRESS	CITY, STATE, ZIP	
HOME PHONE	WORK PHONE	
EMAIL ADDRESS	FAX NUMBER	CELL PHONE

REFERRING PROVIDER INFORMATION

REFERRING PROVIDER	SPECIALTY
STREET ADDRESS	CITY, STATE, ZIP
PHONE NUMBER	FAX NUMBER

INSURANCE INFORMATION (PLEASE FAX AN ENLARGED COPY OF THE FRONT AND BACK OF THE INSURANCE CARDS – THANK YOU)

Primary Insurance	POLICY NUMBER
PHONE NUMBER	GROUP NUMBER

TEST

Schedule with Dr: _____ ❑ No preference

❑ Nerve Conduction Study ❑ Needle Exam ❑ Repetitive Nerve Simulation ❑ Single Fiber EMG

LOCATION

❑ RUE ❑ LUE ❑ RLE ❑ LLE

INDICATIONS (Please check/list identified symptoms of concern – REQUIRED TO SCHEDULE EXAM)

❑ Carpal Tunnel Syndrome ❑ Ulnar Neuropathy ❑ Facial Neuropathy ❑ Other Focal Neuropathy

❑ Peripheral Neuropathy ❑ Radiculopathy ❑ Myopathy ❑ Myasthenia Gravis ❑ Motor Neuron Disease

❑ Other reason _____

Does the patient have any of the following?

❑ Arm or Leg Prosthesis ❑ Warfarin ❑ Dentures ❑ Artificial Heart Valve

❑ Implants ❑ Pacemaker ❑ None

MEDICATION LIST

_____

_____

OTHER COMMENTS:

_____

_____

PRINTED PROVIDER NAME: _____

Signature of Ordering Provider: **Date:**

F6411 (N 11/10)

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