

The Neurology and Electromyography Clinic, P.A.
EMG Request Form

Patient Name: _____ Patient Phone Number: _____

Brief history and findings: _____

Study requested: Upper Extremity Study R L Bilateral
 Lower Extremity Study R L Bilateral
 Generalized Process Study

DDX: (Circle Principal Diagnosis/es)

UE: Cervical Radiculopathy Carpal Tunnel Ulnar Neuropathy
 Brachial Plexopathy Other: _____

LE: LS Radiculopathy LS Plexopathy Meralgia Parasthetica
 Peroneal Neuropathy Other: _____

GEN: Polyneuropathy Myopathy Myasthenia
 Motor Neuron Disease Other: _____

Additional Comments: _____

Check One: _____ Nerve Conduction and EMG only

 _____ NCS/EMG with Consultation

Referred by: _____

Tel No.: _____

Please fax form to The Neurology Clinic (512) 371-1289. Thank you for your referral.