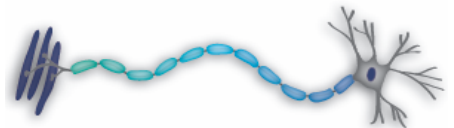
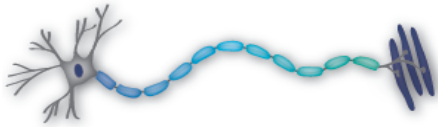


**NEUROMUSCULAR and
ELECTRODIAGNOSTIC
CLINIC**

AT RIVERVIEW HEALTH CENTRE
1 MORLEY AVE. WINNIPEG, MB. R3L 2P4
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REFERRING CLINICIAN: _____	PHONE: _____	FAX: _____
CLINIC ADDRESS: _____		
		DATE: _____ (DD/MMM/YYYY)

PATIENT NAME: _____ PATIENT PHONE: _____
LAST FIRST

PATIENT ADDRESS: _____
STREET CITY POSTAL CODE

PATIENT DOB: _____ MHSC/PHIN: _____
(DD/MMM/YYYY)

NEUROMUSCULAR CONSULTATION & NERVE CONDUCTION STUDIES/ELECTROMYOGRAPHY (EMG)

SYMPTOMS	<input type="checkbox"/> WEAKNESS <input type="checkbox"/> MUSCLE ATROPHY <input type="checkbox"/> ELEVATED CREATINE KINASE (CK) <input type="checkbox"/> MUSCLE CRAMPS/MYALGIAS <input type="checkbox"/> FASCICULATIONS <input type="checkbox"/> NUMBNESS/TINGLING <input type="checkbox"/> FATIGUE/EXERCISE INTOLERANCE <input type="checkbox"/> DOUBLE VISION (DIPLOPIA) <input type="checkbox"/> DYSPHAGIA <input type="checkbox"/> OTHER: _____	SUSPECTED DIAGNOSES	<p><u>ROUTINE UPPER EXTREMITY</u></p> <input type="checkbox"/> CARPAL TUNNEL SYNDROME <input type="checkbox"/> ULNAR NEUROPATHY <input type="checkbox"/> CERVICAL RADICULOPATHY <input type="checkbox"/> TRAUMATIC NEUROPATHY (SINGLE NERVE) <input type="checkbox"/> RADIAL NEUROPATHY (WRIST DROP) <p><u>ROUTINE LOWER EXTREMITY</u></p> <input type="checkbox"/> LUMBOSACRAL RADICULOPATHY <input type="checkbox"/> PERONEAL NEUROPATHY (FOOT DROP) <input type="checkbox"/> TARSAL TUNNEL SYNDROME (TIBIAL NERVE) <input type="checkbox"/> TRAUMATIC NEUROPATHY (SINGLE NERVE) <p><u>COMPLEX:</u></p> <input type="checkbox"/> POLYNEUROPATHY <input type="checkbox"/> MYOPATHY/MUSCULAR DYSTROPHY <input type="checkbox"/> MOTOR NEURON DISEASE (e.g. ALS) <input type="checkbox"/> MYASTHENIA GRAVIS <input type="checkbox"/> BRACHIAL PLEXUS INJURY
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