NEUROMUSCULAR and ELECTRODIAGNOSTIC CLINIC

AT RIVERVIEW HEALTH CENTRE
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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

- ☐ WEAKNESS
- ☐ MUSCLE ATROPHY
- ☐ ELEVATED CREATINE KINASE (CK)
- ☐ MUSCLE CRAMPS/MYALGIAS
- ☐ FASCICULATIONS
- ☐ NUMBNESS/TINGLING
- ☐ FATIGUE/EXERCISE INTOLERANCE
- ☐ DOUBLE VISION (DIPLOPIA)
- ☐ DYSPHAGIA
- ☐ OTHER: _____

SUSPECTED DIAGNOSES

ROUTINE UPPER EXTREMITY

- ☐ CARPAL TUNNEL SYNDROME
- ☐ ULNAR NEUROPATHY
- ☐ CERVICAL RADICULOPATHY
- ☐ TRAUMATIC NEUROPATHY (SINGLE NERVE)
- ☐ RADIAL NEUROPATHY (WRIST DROP)

ROUTINE LOWER EXTREMITY

- ☐ LUMBOSACRAL RADICULOPATHY
- ☐ PERONEAL NEUROPATHY (FOOT DROP)
- ☐ TARSAL TUNNEL SYNDROME (TIBIAL NERVE)
- ☐ TRAUMATIC NEUROPATHY (SINGLE NERVE)

COMPLEX:

- ☐ POLYNEUROPATHY
- ☐ MYOPATHY/MUSCULAR DYSTROPHY
- ☐ MOTOR NEURON DISEASE (e.g. ALS)
- ☐ MYASTHENIA GRAVIS
- ☐ BRACHIAL PLEXUS INJURY

NOTES