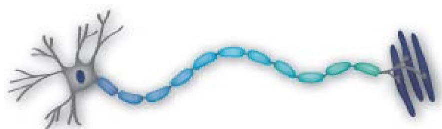

NEUROMUSCULAR and ELECTRODIAGNOSTIC CLINIC

ROBERT A. STEEN DAY HOSPITAL
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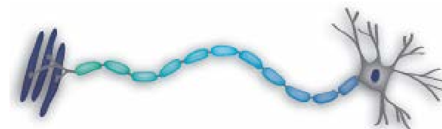

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REFERRING CLINICIAN: ______________________________ PHONE: ________________ FAX: ________________

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)

PATIENT EMAIL ADDRESS: ____

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
- ☐ 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