Referral Form: EMG

Massachusetts General Hospital
Neuromuscular Diagnostic Center
165 Cambridge Street, 8th floor, Suite 820
Boston, MA 02114 Tel: 617 726-3644 Fax: 617 726-2958

Please complete form and fax to 617 726-2958

Date of Note in LMR (Partners referrers only):

* Is the patient on blood thinners/pacemaker (identify below)

Yes - Blood Thinner
Yes - Pacemaker
Yes - Both
No

Pt Contact Number: We will contact your patient and schedule appointment

Referring Physician (Attending name) & phone #:

* Provisional Diagnosis (select all that apply)

Brachial Plexopathy
Carpal Tunnel Syndrome
Cervical Radiculopathy
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
Cranial Neuropathy
Facial Neuropathy
Femoral Neuropathy
Guillain-Barre Syndrome (GBS)
Hereditary Neuropathy
Lambert Eaton
Lumbo-Sacral Plexopathy
Lumbo-Sacral Radiculopathy
Median Neuropathy
Mononeuropathy
Motor Neuron Disease
Myasthenia Gravis
Myopathy
Periodic Paralysis
Peripheral Neuropathy
Peroneal Neuropathy
Radial Neuropathy
Sciatic Neuropathy
Tibial Neuropathy
Ulnar Neuropathy
Other

* Requested Urgency/Reason (identify urgency level)

Routine:
Urgent: Patient seen within 5 days
Emergent: Patient seen same day {Complete form & Call Practice 617 726-3644}

Comments / Patient accommodations and specific needs

Non Partners Facilities: Please indicate the address/fax # where you would like to the EMG test results mailed or faxed:

Name: ____________________________________________________________
Address: _______________________________________________________________________________________________________
Town, State, Zip: ___________________________________________________________________________________________________
Phone: __________________________ Fax: __________________________

Updated 5/24/11