



4520 Colonel Talbot Road
London, Ontario N6P 1B6

URGENT

Bus: (519) 652-2141 Ext. 0
Fax: (519) 652-2138

ELECTRODIAGNOSTIC REQUISITION

Surname: _____

Given Names: _____

Address: _____

City: _____ Postal Code: _____

OHIP No. _____ VC: _____

Phone: _____ Date of Birth: MM/DD/YYYY

Gender: M F UK

WSIB No.: _____ MVA: Y or N

Date of Injury: MM/DD/YYYY

Referring Physician: _____

Address: _____

City: _____ Postal Code: _____

Phone: _____ Fax: _____

Referring Physician Billing No.: _____

Family Physician: _____

Stamp

Check if Applicable: Hepatitis HIV/Aids

Reason(s) for referral:

Carpal Tunnel Syndrome ***	R	<input type="checkbox"/>	L	<input type="checkbox"/>
Ulnar Entrapment	R	<input type="checkbox"/>	L	<input type="checkbox"/>
Peripheral Neuropathy - upper	R	<input type="checkbox"/>	L	<input type="checkbox"/>
Peripheral Neuropathy - lower	R	<input type="checkbox"/>	L	<input type="checkbox"/>
Cervical Radiculopathy	R	<input type="checkbox"/>	L	<input type="checkbox"/>
Lumbosacral Radiculopathy	R	<input type="checkbox"/>	L	<input type="checkbox"/>

Previous EMG Yes No

If yes, Date: MM/DD/YYYY Location: _____

Results: _____

*** Including Management (Injections)

Other Notes / Symptoms:

Please provide copies of pertinent tests (X-rays, CT Scan, MRI, etc): _____

Authorized Signature

Date