Brant Community Healthcare System

Electromyography (EMG)

Tel 519-751-5599
Fax 519-751-5813

Name:_____

Address:_____

City/Province:_____

Postal Code:_____

Phone: Home:_____ Other: _____

Health Card # _____

DOB DD/MM/YYYY _ _ / _ _ / _ _ _ _

IF WSIB, PLEASE COMPLETE THE FOLLOWING: **Sin:** **Claim #:** **Date of Injury:**

Employer's Name & Address:

Referring Physician:	Medications:
Previous Test? ☐ Yes ☐ No	If yes, where?

SERVICES REQUESTED:

☐ EMG and Nerve Conduction Study with Partial Consultation pertaining to the problem

☐ EMG and Nerve Conduction Study with Full Consultation

☐ EMG and Nerve Conduction Study

HISTORY, PHYSICAL EXAM AND DIFFERENTIAL DIAGNOSIS:

What is the question you wish to have answered by this exam:

_____ **Signature of Referring Physician**	**Extra Copies of Report to be Sent to:** **Dr.** **Address:**

For an appointment:
Phone: 519-751-5544 Ext 5599 **Fax: 519-751-5813**

Please attach any recent Lab work and X-ray Reports