



BRANT COMMUNITY HEALTHCARE SYSTEM
ELECTROMYOGRAM (EMG) REQUISITION
 200 Terrace Hill St., Brantford ON N3R 1G9
 Tel: 519-751-5599 Fax: 519-751-5813

For Office Use Only:
 Appointment Date/Time:

REFERRING CLINICIAN INFORMATION		PATIENT INFORMATION	
Name:	Health Card	Version	DOB
OHIP Billing Number:	First Name:	Last Name:	
Address	Address:		
City/Prov:	Postal Code:	City/Province:	Postal Code:
Phone:	Fax:	Phone Number:	Secondary Phone Number:
Signature:	WSIB Claim #:	Secondary Insurance:	
Copies to:	Patient Height:	Patient Weight:	

Does Patient Require Assistance? ☐ Mechanical Lift ☐ Wheelchair ☐ Language Interpreter - Specify:

EXAM REQUESTED (BY APPOINTMENT ONLY) *INCOMPLETE REQUISITIONS WILL BE RETURNED*****

- | | | |
|---|-------------------------------------|-------------------------------------|
| ☐ EMG and Nerve Conduction Study with Partial Consultation pertaining to the problem | ☐ Upper Body | ☐ Lower Body |
| ☐ EMG and Nerve Conduction Study with Full Consultation | ☐ Upper Body | ☐ Lower Body |
| ☐ EMG and Nerve Conduction Study | ☐ Upper Body | ☐ Lower Body |

CLINICAL HISTORY: REASON FOR ORDER

QUESTION YOU WOULD LIKE ANSWERED BY THIS EXAM:

Related Previous Imaging and Labs: ☐ Yes ☐ No If yes, please attach previous if not completed at BGH.

Please include all relevant patient history including previous reports or consult notes as appropriate.