



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

<b>For Office Use Only:</b> Appointment Date/Time:
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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 Consultation  Upper Body  Lower Body  
 EMG and Nerve Conduction Study\*  Upper Body  Lower Body

\* Select only if detailed clinical history and physical exam findings are included in the referral, or if the patient has already had a neurological assessment and the report is attached to this requisition.

**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.**