Referral Form: EMG

nerve conduction studies/needle exam

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

** denotes mandatory information needed*

Patient Name & MRN:

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

*** Interpreter required Y or N** *(circle response)*

Referring Physician (*Attending name*) & phone #:

Name:___________________________________

Phone:__________________________________

*** Referral Reason**

Identify the most applicable reason below, only one

- ☐ Burning
- ☐ Diplopia
- ☐ Dystonia
- ☐ Fasciculation
- ☐ Fatigue
- ☐ Gait Disturbance
- ☐ Myalgia
- ☐ Myotonia
- ☐ Numbness
- ☐ Pain - Back
- ☐ Pain - Limb
- ☐ Pain - Neck
- ☐ Swallowing/Speech Difficulties
- ☐ Tingling
- ☐ Tremor
- ☐ Weakness
- ☐ Reason not listed, list here: __________________

Referral Detail (*identify below*)

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

*** Provisional Diagnosis (*select all that apply*)**

- ☐ Brachial Plexopathy
- ☐ Carpal Tunnel Syndrome
- ☐ Cervical Radiculopathy
- ☐ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)
- ☐ Cranial Neuropathy
- ☐ Facial Neuropathy
- ☐ Femoral Neuropathy
- ☐ Guillian-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