EMG Clinic Requisition

Phone: 519 646-6157
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Appointments include EMG Nerve Conduction Studies and Consultation

Patient **Date of birth** **Address** **Phone** **OHIP#** **WSIB#** **Date of Accident** **Area of Injury**	**<u>Referring Physician:</u>** **Name**: **FAX#** **Phone**: **Address:** **<u>Family Physician:</u>** **Name:** **Address**:
History **Questions to be answered**	
Level of Urgency: ☐ Urgent ☐ Semi-Urgent ☐ Routine	
Signature referring Physician	**Date:**

OFFICE USE ONLY	
Date Received:	**Notes:**