ST JOSEPH'S HEALTH CARE LONDON

DEPARTMENT OF
PHYSICAL MEDICINE AND REHABILIATION
ELECTRODIAGNOSTIC LABORATORY

J#_____
For office use only

EMG REQUISITION

***Patient will not be seen without a requisition.**

Patient **Date of birth** **Address** **Phone** **OHIP#** **WSIB#** **Date of Accident** **Area of Injury**	**Referring Physician:** **Name**: **FAX#** **Phone**: **Address:** **Family Physician:** **Name:** **Address**:

HISTORY

Examination

Questions to be answered.

Includes EMG Nerve Conduction studies and Consultation

Signature referring Physician **Date:**

PLEASE NOTIFY PATIENT OF THEIR APPOINTMENT

DATE OF APPOINTMENT: _____ **TIME:** _____

LOCATION:

EMG Lab
St. Mary's Campus/Mount Hope Site
21 Grosvenor street, main floor, Rm 066
Phone: 519-646-6157 ext:1 Fax: 519-646-6174

Sliding door at front entrance is locked

Please use CODE *2864# (available on intercom) to open door

Please tell your patient to enter the building at 21 Grosvenor and take the 1st hallway to the left. Follow signs on the left wall to the EMG lab located at the top of the wheelchair ramp. Metered parking is available around the building.