EMG REQUISITION
Ph: 519 646-6157
Fax: 519 646-6174

P#_____
For office use only

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	**Level of Urgency:** ☐ **Urgent** ☐ **Semi-Urgent** ☐ **Routine**

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 CLINIC
PARKWOOD INSTITUTE
550 Wellington Road, London ON
Proceed to Entrance 2 - Zone C, take B Elevators, 4th Floor

Visitor Parking Lot #1 $5 Flat fee to enter parking lot

Please bring medication list