ELECTROPHYSIOLOGY REQUEST

PERSONAL INFORMATION

Full Name :

Date Of Birth : _____ /_____ /_____

Address : ____________________

Phone Number : ____________________ **E-Mail address** : ____________________

Emergency contact : ____________________

CLINICAL DETAILS

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Is the patient on warfarin / anticoagulation? : ☐ Yes ☐ No

Does the patient have a permanent pacemaker (PPM)? : ☐ Yes ☐ No

TEST REQUEST

- ☐ Carpal Tunnel Assessment
- ☐ Neuropathy
- ☐ Radiculopathy
- ☐ Single Fibre EMG / Repetitive nerve stimulation (Myasthenia gravis)
- ☐ Small Fibre Neuropathy
- ☐ Other: ____________________

REFERRING DOCTOR DETAILS:

Name : ____________________ **Provider No.** : ____________________

Telephone : ____________________ **Fax** : ____________________

E-Mail : ____________________ **Copies to** : ____________________

Signature : ____________________ **Date** : ____________________

More Information :

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