550 University Ave
Toronto ON, M5G 2A2
Tel: 416-597-3422 x4200
Fax: 416-597-7074

Toronto Rehab - EMG Clinic Referral

Date: _____

Patient Name: _____ **Date of Birth:** _____

Telephone #:_____ **OHIP #**:_____

Address: _____

EMG/NCS and Consult Reason for Referral:

_____

_____

Past Medical History and Medications (or attach information):

_____

_____

Please attach relevant bloodwork, imaging and prior consultation notes.

Our clinic is run by **physiatrists** with EMG certification from the Canadian Society of Clinical Neurophysiology and qualified EMG Technologists. By making this referral, you understand that we will provide your patient with an electrodiagnostic medicine consultation, which includes nerve conduction studies +/- EMG, along with interpretation of the results. This test uses electricity +/- needles. We will provide diagnostic clarification and recommendations for treatment.

Please inform us in advance if your patient has one of the following:

❑ On Warfarin (Provide INR within 48-72hrs of test)	❑ Lymphedema in the symptomatic limb
❑ Needle phobia	❑ Wounds or ulcers in the symptomatic limb
❑ Neurostimulators	❑ Bandaging or wraps in symptomatic limbs

Referral Urgency: ❑ Routine ❑ Urgent - explain: _____

Please book with: ❑ 1st available physician or please specify physician:

❑ Dr. T. Bruno ❑ Dr. J. Farag ❑ Dr. M. Guo ❑ Dr. E. Mauti ❑ Dr. H. Sangha

Referring Physician Name: _____

Billing #:_____ **Telephone:** _____

Fax:_____ **Signature:** _____