GRAND RIVER HOSPITAL
Advancing Exceptional Care

EMG TESTING CLINIC
Physical Medicine and Rehabilitation
Outpatient Referral Form

Freeport Campus, Pioneer Terrace 1st Floor
3570 King Street East, Kitchener, Ontario, N2A 2W1
Phone: 519-749-4300, ext. 7860 Fax: 519-894-8310

Patient's Last Name:	Patient's First Name:	Initial:	❑ Male ❑ Female ❑ Other_____
DOB (year/month/day):	Health Card #:	Version Code:	WSIB Claim #:
Street Address:	City:	Province:	Postal Code:
Patient's Phone:	Cell Phone:	The patient consents to messages being left at this number ❑ Yes ❑ No	

Services Requested:

❑ EMG	❑ EMG with Consultation

History:

Reason for Referral:

Additional Comments:

To ensure the most appropriate intervention, please include relevant operative reports, consult notes, imaging results, and rehabilitation therapy reports (unless available through Clinical Connect).

Referring Physician Name (please print):	Physician's Phone #:	Physician's Fax #:
Physician's Signature:	Physician's Billing #: (Required)	

Revised: 15 FEB 2024