

EMG TESTING

**Physical Medicine and Rehabilitation Clinic
Freeport Campus, Pioneer Terrace 1st Floor**

Phone: (519) 749-4300 ext. 7860 Fax: (519) 894-8310

Patient Name (Last, First):		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (YYYY/MM/DD):
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Health Card #:	WSIB Claim #:	Patient's Phone #:	Patient consents to message being left at this number: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Services Requested:

EMG EMG with Consultation

History

Reason for Referral

In order 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 #:	Fax #:
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Physician's Signature:	Billing Number (required):
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