Providence Health Care

SPH DIAGNOSTIC NEUROPHYSIOLOGY EMG/NERVE CONDUCTION STUDIES REQUISITION

* 7 8 4 1 *

Requisition form

Place Patient Label Here

St. Paul's Hospital Department of Diagnostic Neurophysiology **Phone:** 604-806-8646 **FAX:** 604-806-8624
1081 Burrard Street, Providence Building, Vancouver, BC

PATIENT INFORMATION (Print clearly) **WorkSafe BC:** _____ **ICBC:** _____

Surname: _____ First name: _____ Middle name: _____

PHN**:** _____ DOB**:** (dd/mmm/yyyy) _____ Gender: ☐ Male ☐ Female ☐ Other: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: Home: _____ Work/Cell: _____

Family Physician: ☐ No ☐ Yes Name: _____

REFERRING PROVIDER

Name: _____ Signature: _____

MSP number: _____ Phone: _____ Fax: _____

Date of Referral: (dd/mmm/yyyy)_____ Copies to: _____

☐ **URGENT** ☐ **NON-URGENT**

Patient prefers appointment in: ☐ Morning ☐ Afternoon
Patient preference will be considered but cannot be guaranteed.

HISTORY AND CLINICAL FINDINGS

_____

_____

Tentative Diagnosis: _____

Medication(s): _____

Allergies/Sensitivities: _____ Patient's special needs: (if any) _____

Attach all relevant investigations and consult letters:

☐ Consult letters from specialists (e.g.: neurology, physiatry)
☐ Recent imaging
☐ Recent bloodwork (e.g.: TSH, vitamin B12, fasting glucose, A1C, serum protein electrophoresis)

CARPAL TUNNEL SYNDROME + PATHWAY

If your patient is experiencing symptoms of a compression neuropathy, they will be seen by the Carpal Tunnel Plus Integrated Practice Unit, which includes team-based care, patient-oriented outcome measurement, and expedited access to surgical consult if indicated.

☐ Carpal Tunnel Syndrome	☐ Ulnar Neuropathy	☐ Fibular Neuropathy
☐ Right ☐ Left ☐ Bilateral	☐ Right ☐ Left ☐ Bilateral	☐ Right ☐ Left ☐ Bilateral

Please check all symptoms that apply

☐ Experiencing severe pain	☐ Objective weakness or wasting	☐ No improvement after 6 weeks of wearing splints
☐ Interference with daily activities	☐ Frequent nocturnal wakening	

APPOINTMENT BOOKING

Date of Appointment: _____ Time: _____

With Dr. _____