



EMG Requisition
Neurodiagnostics Clinic

1235 Wilson Avenue – Portal of Care B, Level 1

APPOINTMENT DATE: \_\_\_\_\_ Time: \_\_\_\_\_

PHYSICIAN (check one):

- Dr. D. Morgenthau
Dr. Y. Jiang
Dr. K. Hsu (Physiatrist)
Dr. R. Magder
Phone: 416-614-8711
Fax: 416-614-7566
Phone: 416-242-1000 ext. 47202
Fax: 416-242-1066

Patients Name: \_\_\_\_\_ DOB: (d/m/yr) \_\_\_\_\_
HCN: \_\_\_\_\_ Version: \_\_\_\_\_
Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_
Phone: (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_

Request (check one):

- Consultation, EMG, and Management
EMG only

Reason for referral: \_\_\_\_\_

Ref. Physician: \_\_\_\_\_ Billing Number: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Additional Copy to: \_\_\_\_\_

\*\*\*\*\*Instructions: Please NO hand cream or body lotion and wear loose clothing\*\*\*\*\*