**REQUISITION FORM FOR**

**EMG and NCS**

**Electomyography and Nerve Conduction Studies**

**Fax To: (808) 483-8822 Oahu**

**Fax To: (808) 969-8189 Big Island**

Premier Neurology and Sleep Medicine Center

Dr. Michael Slattery

**Board Certified** in **Sleep Medicine**

American Board of Psychiatry and Neurology

Added qualifications in Sleep Medicine

**Board Certified** in **Sleep Medicine**

American Board of Sleep Medicine

**Board Certified** in **Neurology**

American Board of Psychiatry and Neurology

**Board Certified** in **Psychiatry**

American Board of Psychiatry and Neurology

**Board Certified** in **Clinical Neurophysiology**

American Board of Psychiatry and Neurology

Added qualifications in Clinical Neurophysiology

**Board Certified**: American Board of Clinical **Neurophysiology**

(EEG/EP) with Special Competence in Epilepsy Monitoring

**Pearl City  Honolulu  Kailua Kona  Hilo**

98-1238 Kaahumanu St #300 1188 Bishop St #2511-12 75-167 Kalani St #205 56 Kamehameha Ave

Pearl City, HI 96782 Honolulu, HI 96813 Kailua Kona, HI 96740 Hilo, HI 96720(808)

456-REST (7378) (808) 456-REST (7378) (808) WOW-REST (969 -7378) (808) WOW-REST (969 -7378)

**PATIENT INFORMATION:**

Name:

Address:        Date of Birth:

Home Phone:        Cell Phone:

E-mail Address:        **INSURANCE INFORMATION: Please check with insurance carrier to obtain prior authorization if applicable.**

Insurance Carrier:        Member#:        Auth#:

Responsible Party name:        Responsible Party DOB:        **REFERRING PHYSICIAN:**        Specialty:        Contact Person:

Phone:        Fax:        Email Address:

Address:       Cc: Physician:

Please attach a medication list and any clinical notes pertaining to nerve or muscle problems if available

**TYPE OF SERVICE REQUESTED: Please check at least one box before submitting.**

1. **Consultation and EMG/NCS**

2.  **EMG/NCS testing alone**

Chief Complaint:

SUSPECTED DIAGNOSIS/SYMPTOMS:

**Duration of Symptoms:**        **Medical Hx:**

Is Patient on Anticoagulants?  Yes  No **If so which ones**?

Does patient require Personal Assistance:  Yes  No

Does patient have a Pacemaker:  Yes  No

Does patient have a Defibrillator  Yes  No

Does patient have a Bleeding Disorder:  Yes  No

Has patient had any MRI’s of the neck,

low back or brain?  Yes  No

EMG/NCV of: R/O

Right upper Extremity  Carpal Tunnel Syndrome

Left Upper Extremity  Ulnar Neuropathy

Right Lower Extremity  Tibial Neuropathy

Left Lower Extremity  Peroneal Neuropathy

Peripheral Neuropathy

Other:

Referring physician’s signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by Dr. Slattery Revised Jan 2015

Board Certified in Clinical Neurophysiology by the American Board of Psychiatry and Neurology