**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:

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Reviewed by Dr. Slattery Revised Jan 2015

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