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Tel: (587) 481-7866
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www.southlandemg.com

EMG Referral Form

Dr. Serge Mrkobrada MD, MSc, FRCPC, CSCN Diplomate (EMG)

PATIENT INFORMATION (can use label)

Name:_____ Gender:_____

Date of Birth:_____ ULI: _____

Address:_____

Phone: (H)_____ (W)_____

REFERRAL INFORMATION

Priority: Urgent ☐ Routine ☐

Urgent requests must be discussed by direct consultation with Dr. Mrkobrada

Referring physician

Name:_____

Phone:_____ Fax:_____

PRACID:_____

Clinical question

Carpal tunnel syndrome ☐
Ulnar neuropathy ☐
Polyneuropathy ☐
Cervical radiculopathy ☐
Lumbosacral radiculopathy ☐
Plexopathy ☐
If other, please specify:

Clinical information (please attach previous EMG studies, consults, relevant imaging, bloodwork and medications)

Past medical history

Diabetes ☐
Thyroid disease ☐
HIV or Hepatitis C ☐
Alcohol abuse ☐
Other:
Is the patient on anticoagulation: ☐Yes ☐No

Physician's signature: Date:

Please fax completed form to Southland EMG, fax # (587) 481-7877