SUNY DOWNSTATE Medical Center

NAME:

MR #

N.S.

Service/Doctor

REQUEST FOR CONSULTATION AND EMG

Date of request: _____

Requesting Attending MD: _____

Requesting Resident / Fellow: _____

☐ Outpatient ☐ Inpatient / Admission Date: _____

Location (specify clinic, ward or nursing station): _____

Previous EMG at SUNY DMC: ☐ No ☐ Yes Year: _____

Clinical Diagnosis: _____

_____

_____

Medications: _____

Consultation requested: ☐ No ☐ Yes

Study requested:

☐ Nerve Conduction Studies

☐ Needle Electromyography

☐ Neuromuscular Transmission (Repetitive Stim.)

☐ Neuromuscular Transmission (Single Fibre EMG)

☐ Blink Reflexes

☐ Quantitative Tremor Analysis

☐ Neuromagnetic Stimulation of Caude Equina (demyelinating neuropathy)

☐ Autonomic Studies

History and Specific questions: