Referral Form Dr. Jamila Madhani

203-5704 Balsam St. Vancouver BC V6M 4B9

Tel: 604 428 7178 **Fax**: 604 429 7860

Referring MD Name	______________________	**Ref. Date:**	_________________________
		Ref. Desk #:	_________________________
Referring MD MSP	______________________	**Referral For**	
GP Name	______________________	☐ **EMG Nerve Conduction (Richmond Hosp)**	
URGENT	Y ☐ N ☐	☐ **General Neuro Consult (Kerrisdale Office)**	

FIRST NAME:	______________________	**LAST NAME:**	_________________________
PHN:	______________________	**Home #**	_________________________
DOB: *mm/dd/yyyy*	______________________	**Mobile #**	_________________________
Street Address	______________________	**Work #**	_________________________
City	______________________	**Email**	_________________________
Postal Code	______________________		_________________________

Brief Patient History & Clinical Diagnosis:

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COMPLETE BELOW FOR ALL EMG/NCS Referrals		
Anticoagulation:	**Side of Symptoms**	
Y ☐ N ☐ **Type:**__________________	**Left:** ☐ **Right:** ☐ **Bilateral:** ☐	
Upper Extremity Involvement	**Lower Extremity Involvement**	
☐ **Fingers Digits affected:** _______ ☐ **Hands** ☐ **Lower Arm** ☐ **Upper Arm**	☐ **Toes** ☐ **Foot** ☐ **Leg**	
Peripheral Neuropathy	**Radiculopathy**	**Demyelinating Neuropathy**
☐ Ulnar	☐ Cervical	☐ CIDP
☐ Median / Carpal Tunnel Syndrome	☐ Lumbar/Sacral	☐ GBS/AIDP
☐ Radial	☐ Specific Level: _____	☐ Hereditary / CMT
☐ Sciatic		
☐ Peroneal/Fibular	**Plexopathy**	**Neuromuscular Junction**
☐ Tibial	☐ Brachial	☐ MG ☐ Ach Receptor Ab +
☐ Femoral	☐ Lumbar / Sacral	☐ LEMS
☐ Other: ____________________		☐ Botulism_
Muscle:		
☐ Motor Neuron Disease /ALS	☐ Myopathy	☐ Motor Neuron Disease /ALS
☐ Periodic Paralysis	☐ Muscular Dystrophy	☐ Periodic Paralysis

Please attach

☐ **allergies** ☐ **medication list** ☐ **past medical history** ☐ **relevant consults** ☐ **relevant imaging** ☐ **labs**