NORTH SHORE MEDICAL CENTER

NEURODIAGNOSTIC TESTING REQUEST FORM

EMG/EEG/NCV/EP

Please fax the completed form to **(978) 740-4880**

Patient Name: _____ DOB: _____

Address: _____

Home Phone: _____ Cell Phone: _____

If the appointment is to be scheduled by someone other than above

Contact Name: _____ Phone:_____

Primary Insurance: _____ID# _____

Subscriber: _____

Workers Compensation Information

Insurance Company: _____ Address: _____
Person Handling Case: _____ Phone: _____
Claim # _____ Accident Date: _____

Please check the requested test:

Electromyography (EMG/NCV)
Upper ☐ Lower ☐
Right ☐ Left ☐ Both ☐

Evoked Potentials (EP)
Visual ☐ Auditory ☐
Somatosensory ☐ Arms ☐ Legs ☐

Electroencephalography (EEG)
Wake ☐ Sleep ☐

Reason for testing: _____
_____

Prior EEG Testing: Yes ☐ No ☐
Date: _____ Location: _____

Ordering Physician: _____ Phone:_____Fax:_____

Primary Physician: _____ Phone:_____Fax:_____

Ordering MD Signature: _____ Date of Exam: _____

Form date 7/1/2018