EMG *and* NERVE CONDUCTION STUDY
CONSULTATION REQUEST FORM

SELK PHYSICAL MEDICINE & EMG
POINT 9 BUILDING
106-311 Ludlow St
Saskatoon, SK S7S1N6
Phone: 306-975-3933
Fax: 306-975-3931

Dr. B. Selk

Outpatient ☐

Inpatient ☐ Location _____

NAME

Surname *First Name*

ADDRESS	Street:
	City: Postal Code:
TELEPHONE	Home:
	Work:
PERSONAL HEALTH NUMBER	

DATE OF BIRTH	*DD / MM / YY*	Gender:	☐ Male ☐ Female
REFERRING PHYSICIAN		TELEPHONE	

CLINICAL INFORMATION: Circle Right, Left or Both

- ☐ Carpal Tunnel Syndrome. ☐ Right ☐ Left ☐ Both
- ☐ Ulnar Neuropathy ☐ Right ☐ Left ☐ Both
- ☐ Cervical Radiculopathy ☐ Right ☐ Left ☐ Both
- ☐ Lumbar Radiculopathy ☐ Right ☐ Left ☐ Both
- ☐ Polyneuropathy
- ☐ Myopathy

Other:

_____

Physician Signature