NEURON MEDICAL CORP.
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For convenient scheduling, please call 805-373-2890
or fax your request form to our toll-free fax 1-800-746-3510.

Patient name:

Phone: Date:

Referring Physician:

Referring physician phone: Fax:

Reason for referral, diagnosis, symptoms:

PLEASE SEND PATIENTS INSURANCE INFORMATION WITH THIS FORM

☐ Electrodiagnostic consult:

- Consultation with physician to see the patient
- Any required pre-certs will be obtained and appropriate test scheduled if needed
- Physician will report finding and help implement a treatment plan.

Neuromuscular assessment:	Right	Left	Both if needed
☐ EMG/Nerve conduction legs	____	____	____
☐ EMG/Nerve conduction arms	____	____	____
☐ Blink reflex			____
☐ Repetitive nerve stimulation (ex.- for myasthenia gravis)	____	____	____

EEG assessment
☐ EEG-routine
☐ EEG-sleep-deprived
☐ EEG- 24-hr ambulatory (similar to Holter for cardiac workup, to clarify syncopal or seizure episodes)

☐ EEG- 48 hr ambulatory (similar to Holter for cardiac workup, to clarify syncopal or seizure episodes)

Symptoms:

☐ Back injury	☐ encephalopathy	☐ sciatica/lumbago
☐ back pain	☐ foot drop/wrist drop	☐ syncope
☐ back surgery	☐ limping	☐ twitching sensation
☐ burning sensation	☐ loss of balance	☐ weakness
☐ convulsions	☐ muscle weakness	☐ other_____
☐ carpal tunnel	☐ neck injury	
☐ diabetes	☐ numbness	
☐ difficulty walking	☐ pain in limbs	

Referring Physician
Signature_____