RHODE ISLAND HOSPITAL
ELECTROMYOGRAPHY/EVOKED POTENTIAL
REQUEST FORM

FAX: (401) 444-5929 PHONE: (401) 444-4882

Patient's Name: _____ **Patient's DOB:** _____

Patient's Address: _____

_____

Patient's Phone: _____

Patient's Primary Insurance: _____

ID #_____ Primary Subscriber_____

Patient's Secondary Insurance: _____

ID #_____ Primary Subscriber_____

TESTS REQUESTED

- ☐ Nerve conduction studies (NCS)
- ☐ EMG
- ☐ Repetitive stimulation
- ☐ Blink Reflex
- ☐ Single fiber EMG
- ☐ RR Interval
- ☐ Sympathetic skin response
- ☐ Ischemic Exercise Test
- ☐ Somatosensory evoked potentials (upper extremities)
- ☐ Somatosensory evoked potentials (lower extremities)
- ☐ Brainstem auditory evoked potentials
- ☐ Visual evoked potentials

SYMPTOMS: _____

DIAGNOSIS (ICD-9 CODES) / RULE OUT: _____

_____

REQUESTING PHYSICIAN

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone: _____

FAX # for PreLim: _____

Primary Care Physician: _____

DOCTOR'S SIGNATURE: _____

* ALL areas must be completed or the study cannot be scheduled.