ByWard
MÉDECINE DU SPORT & PHYSIOTHÉRAPIE
www.bywardfht.ca
Tel/Tél: 613-564-3950

Capital EMG PHYSIATRISTS

ByWard
SPORTS MEDICINE & PHYSIOTHERAPY
www.bywardfht.ca
Fax/Téléc: 613-564-6627

Date:

EMG/NCS Clinic Referral

Referring Physician

Name _____ Billing # _____

Address _____

_____

Phone _____ Fax _____

Signature _____

Patient

Name _____

Address _____

_____

Prov. Health # _____ Expiry _____ (yyyy-mm-dd) Birth Date _____ (yyyy-mm-dd)

Phone _____ Language: ☐ Eng ☐ Fr ☐ Eng & Fr

☐ WSIB ☐ MVA ☐ Varsity

Referral Priority

☐ Urgent ☐ Routine

Referral for Consult and EMG Testing to

☐ **First Available Physician**

Or indicate a specific Provider ☐ **Dr. Scott Wiebe** ☐ **Dr. Colin Mascaro** ☐ **Dr. Gerald Wolff**

Clinical Details and Referral Question

Tentative Diagnosis _____

Please attach patient profile including past medical history & current medications.

**** PLEASE BE SURE TO FORWARD ALL RELEVANT IMAGING/LAB WORK WITH THIS REFERRAL. ****

Patient Specifics

Patient's Special Needs (if any) _____

_____

Previous Study (EMG/imaging) _____