AMMC Neurology Associates 4000 Linwood Dr., Ste. G Paragould Ar, 72450

Referral Form

Incomplete and illegible forms will be returned Phone: (870)205-2175 Fax: (870)205-2180

Circle the service requested

| Phone: (870)205-2175 Fax: (870)205-2180 | Consultation only | Consultation with EMG/NCS |
|---|----------------------------------|--|
| Patient Information: | | |
| Name: | | MaleFemale |
| Address: | | |
| DOB (DD/MM/YYYY):// | Contact phone number_ | |
| Referring Provider: | | |
| Name: | | |
| Address: | | |
| Phone: Fax: | | |
| Diagnosis and reason for referral (If testing n | needed, please put if arms or le | egs) |
| Please attach results of previous investigations, man | agement, and consult & foll | low-up notes relevant to this referral |
| f applicable, please list the name and date of last ass | sessment by a neurologist (| inpatient/ER/clinic) |
| List relevant previous or planned investigations | | |
| Please attach a copy | of insurance card and PA if | required |
| C | OFFICE USE ONLY | |
| Appointment scheduled for : | | |
| Patient notified : | | |
| Comments: | | |



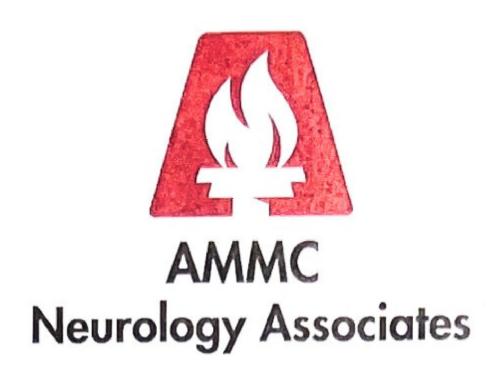
Neurology Associates

EMG / NCS Referral Form Please fax completed from to 870-205-2180

| Referring Physician Name: | Yes – Blood Thinner Yes – Pacemaker Yes – Both No Provisional Diagnosis Brachial Plexopathy Carpal Tunnel Syndrome Cervical Radiculopathy Chronic Inflammatory Demyelinating |
|--------------------------------------|---|
| Referring Physician Name: | Provisional Diagnosis |
| Name: | Provisional Diagnosis O Brachial Plexopathy O Carpal Tunnel Syndrome O Cervical Radiculopathy O Chronic Inflammatory Demyelinating |
| Referring Physician | Provisional Diagnosis |
| Name: | o Brachial Plexopathy o Carpal Tunnel Syndrome o Cervical Radiculopathy o Chronic Inflammatory Demyelinating |
| Name: | o Brachial Plexopathy o Carpal Tunnel Syndrome o Cervical Radiculopathy o Chronic Inflammatory Demyelinating |
| Name: | o Brachial Plexopathy o Carpal Tunnel Syndrome o Cervical Radiculopathy o Chronic Inflammatory Demyelinating |
| Name: | o Carpal Tunnel Syndrome o Cervical Radiculopathy o Chronic Inflammatory Demyelinating |
| | Cervical Radiculopathy Chronic Inflammatory Demyelinating |
| | o Chronic Inflammatory Demyelinating |
| | |
| Phone #: | e t t t t t t t t t t t t t t t t t t t |
| Phone #: | Polyneuropathy(CIDP) |
| | o Cranial Neuropathy |
| | o Facial Neuropathy |
| C D C 1 1 - 1 | o Femoral Neuropathy |
| leason for Referral / Testing: | o Guillian-Barre Syndrome (GBS) |
| o Burning | o Hereditary Neuropathy |
| o Diplopia | o Lambert Eaton |
| o Dystonia | o Lumbo-Sacral Plexopathy |
| o Fasciculation | o Lumbo-Sacral Radiculopathy |
| o Fatigue | Median Nueropathy |
| o Gait Disturbance | o Mononeuropathy |
| o Myalgia | o Motor Neuron Disease |
| o Myotonia | o Myasthenia Gravis |
| o Numbness | o Myopathy |
| o Pain-Back | Periodic Paralysis |
| o Pain-Limb | o Peripheral Neuropathy |
| o Pain-Neck | Peroneal Neuropathy |
| Swallowing/Speech Difficulties | Radial Neuropathy |
| | Sciatic Neuropathy |
| | o Tibial Neuropathy |
| o Tremor | Ulnar Neuropathy |
| o Weakness | o Other |
| O Reason not listed (describe below) | C Other |

Please attach a copy of the patient's insurance card and PA if required by insurance

CONTINUED ON NEXT PAGE



EMG / NCS Referral Form continued

Patient:

| Please indicate the address/fax # where you would like the EMG test results mailed or faxed | | |
|---|----------|---|
| Name: | | |
| Address: | | |
| Town, State | te, Zip: | |
| Phone: | Fax: | _ |

INSURANCE CARD COPY OR INFORMATION CAN BE ATTACHED OR PRINTED BELOW: