

Referral Form Dr. Jamila Madhani

3368 Dunbar St. Vancouver BC V6S 2C1

Tel: 604 428 7178 Fax: 604 428 7860

Referring MD Name _____ Referring MD MSP _____ GP Name _____ URGENT Y <input type="checkbox"/> N <input type="checkbox"/>	Ref. Date: _____ Ref. Desk #: _____ Referral For <input type="checkbox"/> EMG Nerve Conduction (Richmond Hospital) <input type="checkbox"/> General Neuro Consult (Vancouver Office)
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FIRST NAME: _____ PHN: _____ DOB: mm/dd/yyyy _____ Street Address _____ City _____ Postal Code _____	LAST NAME: _____ Home # _____ Mobile # _____ Work # _____ Email _____
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Brief Patient History & Clinical Diagnosis:

Must Include to avoid the delay of referral must have all the attachment below:

- allergies
 medication list
 past medical history
 relevant consults
 relevant imaging
 labs

COMPLETE BELOW FOR ALL EMG/NCS Referrals		
Anticoagulation:	Side of Symptoms	
Y <input type="checkbox"/> N <input type="checkbox"/> Type: _____	Left: <input type="checkbox"/> Right: <input type="checkbox"/> Bilateral: <input type="checkbox"/>	
Upper Extremity Involvement	Lower Extremity Involvement	
<input type="checkbox"/> Fingers Digits affected: _____ <input type="checkbox"/> Hands <input type="checkbox"/> Lower Arm <input type="checkbox"/> Upper Arm	<input type="checkbox"/> Toes <input type="checkbox"/> Foot <input type="checkbox"/> Leg	
Peripheral Neuropathy	Radiculopathy	Demyelinating Neuropathy
<input type="checkbox"/> Ulnar	<input type="checkbox"/> Cervical	<input type="checkbox"/> CIDP
<input type="checkbox"/> Median / Carpal Tunnel Syndrome	<input type="checkbox"/> Lumbar/Sacral	<input type="checkbox"/> GBS/AIDP
<input type="checkbox"/> Radial	<input type="checkbox"/> Specific Level: _____	<input type="checkbox"/> Hereditary / CMT
<input type="checkbox"/> Sciatic		
Peroneal/Fibular	Plexopathy	Neuromuscular Junction
<input type="checkbox"/> Tibial	<input type="checkbox"/> Brachial	<input type="checkbox"/> MG <input type="checkbox"/> Ach Receptor Ab +
<input type="checkbox"/> Femoral	<input type="checkbox"/> Lumbar / Sacral	<input type="checkbox"/> LEMS
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Botulism_
Muscle:		
<input type="checkbox"/> Motor Neuron Disease /ALS	<input type="checkbox"/> Myopathy	<input type="checkbox"/> Motor Neuron Disease /ALS
<input type="checkbox"/> Periodic Paralysis	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Periodic Paralysis

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