# Referral Form Dr. Jamila Madhani

3368 Dunbar St. Vancouver BC V6S 2C1 (Mailing Address)
**Tel**: 604 428 7178 **Fax**: 604 428 7860

| | | | |
|---|---|---|---|
| **Referring MD Name** | _____ | **Ref. Date:** | _____ |
| **Ref. Desk #:** | _____ | **Referring MD** | _____ |
| **Referring MD MSP** | _____ | **Referral For** | |
| **GP Name** | _____ | ☐ **EMG Nerve Conduction** | |
| **URGENT** | Y ☐ N ☐ | ☐ **General Neuro Consult** | |

| | | | |
|---|---|---|---|
| **FIRST NAME** | _____ | **LAST NAME:** | _____ |
| **PHN:** | _____ | **Home #** | _____ |
| **DOB:** *mm/dd/yyyy* | _____ | **Mobile #** | _____ |
| **Street Address** | _____ | **Work #** | _____ |
| **City** | _____ | **Email** | _____ |
| **Postal Code** | _____ | | _____ |

**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 ☐ N ☐ **Type:**_____ | **Left:** ☐ **Right:** ☐ **Bilateral:** ☐ | |
| **Upper Extremity Involvement** | **Lower Extremity Involvement** | |
| ☐ **Fingers Digits affected: _____**<br>☐ **Hands**<br>☐ **Lower Arm**<br>☐ **Upper Arm** | ☐ **Toes**<br>☐ **Foot**<br>☐ **Leg** | |
| **Peripheral Neuropathy** | **Radiculopathy** | **Demyelinating Neuropathy** |
| ☐ Ulnar | ☐ Cervical | ☐ CIDP |
| ☐ Median / Carpal Tunnel Syndrome | ☐ Lumbar/Sacral | ☐ GBS/AIDP |
| ☐ Radial | ☐ Specific Level: _____ | ☐ Hereditary / CMT |
| ☐ Sciatic ☐ Peroneal/Fibular | **Plexopathy** | **Neuromuscular Junction** |
| ☐ Tibial ☐ Femoral | ☐ Brachial | ☐ MG ☐ Ach Receptor Ab + |
| ☐ Other: _____ | ☐ Lumbar / Sacral | ☐ LEMS ☐ Botulism |
| **Muscle:** | | |
| ☐ Motor Neuron Disease /ALS | ☐ Myopathy | ☐ Other |
| ☐ Periodic Paralysis | ☐ Muscular Dystrophy | |