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**

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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:** _______ ☐ **Hands** ☐ **Lower Arm** ☐ **Upper Arm**	☐ **Toes** ☐ **Foot** ☐ **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	