REFERRAL/ORDER FORM EMG/NERVE CONDUCTION

505 Farmington Ave, Farmington, CT. 06032
PHONE: 860.837.6646 FAX:860.837.6657

Connecticut Children's Patient Label
for internal use only

Patient Name: (Last) ______________________ (First) ______________________

Street Address: ______________________

City/State/Zip: ______________________ **Date of Birth:** ______________________

Preferred Phone: (Home) ____________ (Work) ____________ (Cell) ____________

Parent/Guardian/DCF: ______________________**Preferred Language:** ______________________

If DCF: (Social Worker name) ______________________ (Phone) ______________________

This visit is: ☐ Routine ☐ Semi-urgent (within 2 weeks) **Urgent: Please call Neurodiagnostics Department for further discussion. 860.837.6646**

Insurance:______________________ **ID#** ______________________

Type of study requested: ☐ **Nerve Conduction/EMG** ☐ **Repetitive Stimulation**

Provisional/Rule out diagnosis/Question(s) to be answered by procedure(s):______________________

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Positive Clinical Findings:______________________

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Pertinent Lab Fidings:______________________

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Sedation: We can obtain an EMG for most children without Sedation. We suggest to attempt an EMG WITHOUT sedation in ALL patients first unless you feel it is necessary. Sedation will be used to allow for proper recording of waves only in patients who are not cooperative and combative. If the test is unsuccessful, we will offer to reschedule the test with sedation.

Has the patient previously needed sedation for an EEG? ☐ Yes ☐ No

Has the patient previously tried to do an EEG without sedation and been unable to complete the test? ☐ Yes ☐ No

If you answered YES to either of the questions above, the patient should be scheduled with sedation.

☐ This patient requires sedation in order to obtain an EMG. Please complete sedation order. The patient will not be scheduled until the sedation form is completed and returned to us.

Please note: 1) If sedation is used, the patient will need to be NPO and will need to recover from the sedation in the sedation suite for an average of 1-2 hours after the test. 2) The sedation team will decide what is the most appropriate sedative for the patient.

REFERRING PROVIDER INFORMATION

Referring Provider: ______________________

Referring Provider: (Phone) ______________________ (Fax) ______________________

Patient's Primary Care Physician (if different from referring)**:** ______________________

Is the family aware of the reason for referral? ☐ Yes ☐ No

______________________ Date ________ Time ______
Signature/Credentials of ordering Practitioner (APRN, PA, Non-resident MD or DO)

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