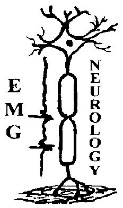
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**EMG/NCS REFERRAL FORM**

Mary L. Lussier, MD

250 Wampanoag Trail, Suite 204

East Providence, RI 02915-2214

Phone: 401-438-2400 Fax: **401-438-2422**

**Dear Referring Provider:**

Please put check marks in all appropriate boxes below, and attach to this fax:

-Demographic sheet, including Insurance information.

-Most recent Office note.

Thank you for your referral!

**Fax to: 401-438-2422 REASON FOR REFERRAL**

***UPPER EXTREMTIY*:**

**LEFT RIGHT BILATERAL**

Carpal Tunnel Ulnar Neurop. Guyon Cervical Radiculopathy

*Median n. at wrist at Elbow (****cubital****) Ulnar at (****wrist)***

Brachial Plexus Other Diagnosis/Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***LOWER EXTREMITY*:**

**LEFT RIGHT BILATERAL**

Lumbosac Radic Peroneal N. Peripheral Polyneuropathy

Other Diagnosis/Symptoms:

**Patient's** Name: Best Phone #:

**Referring Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: Ext.

Office Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:

Primary Care MD (**if** referral required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:

\***WORKERS COMP if** required**:**

**DOI:\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_CLAIM#:** **INSURANCE COMPANY:**

Has the EMG/NCS been approved? \_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_ No

Are you seeking approval? \_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_ No

***For******Dr. Lussier’s Office Use Only***:

VM for Pt. \_\_\_/\_\_\_/\_\_\_ \_\_\_:\_\_\_ Home/Cell/Work VM for Pt. \_\_\_/\_\_\_/\_\_\_ \_\_\_:\_\_\_. Home/Cell/Work

**Appointment Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **Part 2 or RS Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**Time:** \_\_\_\_\_:\_\_\_\_\_\_ A.M./P.M. **Time:** \_\_\_\_\_:\_\_\_\_\_\_ A.M./P.M.