

MELBOURNE NEUROLOGY



www.melbourneneurology.com.au

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ELECTROPHYSIOLOGY TEST/NEUROLOGY CONSULTATION REQUEST

PATIENT DETAILS

Name: _____ Date of Birth: / / _____

Address: _____

Telephone: _____

CLINICAL DETAILS

TEST/S REQUESTED

Nerve Conduction Studies/EMG:

Single Fibre EMG (Kew rooms only)

Consult needed: Yes No

REFERRING DOCTOR DETAILS

Name: _____ Provider no: _____

Address for report: _____

Telephone: _____ Fax: _____

Copies to: _____

Signature: _____ Date: / / _____