Stanford HEALTH CARE

**Need Assistance?**
Physician Helpline: 866-742-4811

prism

# EMG & NCS Ordering Form

## Patient Information

## Reason for Referral

Priority: Routine ☐ **Urgent** ☐

Name *(Last Name, First Name)* Sex: ☐ Male ☐ Female

sdadsadsa

Date of Birth

Phone #

Secondary #

Address

City State Zip Code

**If Medically Urgent**, please describe:

Diagnosis/ICD 10

Physician Requested

Location Requested

NDL- Palo Alto ☐ NDL- Emeryville ☐

If Requested Physician is Unavailable,
Can Patient be seen by another provider?

☐ Yes ☐ No ■ Contact Referring Provider

## Referring Provider Information

| | | |
|---|---|---|
| Referring Provider Name | | |
| Practice Name | | |
| Office Address | | City |
| State | ZIP Code | NPI Number |
| Phone | Fax** | |

## EMG Testing Information

| | | | |
|---|---|---|---|
| Is patient taking anticoagulants? | Yes ◉ | No ○ | If Yes, Name and Dose |
| Clinical Question: | | | |
| Single Fiber? | Yes ◉ | No ○ | |
| Is this study for blepharospasm, hemifacial spasm, dystonia, or myocolonus? | Yes ◉ | No ○ | |