The Centers for Advanced Orthopaedics

Orthopaedic Associates of Central Maryland Division

ELECTROMYOGRAPHY (EMG/NCS) Referral Form

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Patient Name: ______________________ **DOB:** ______________ **Phone:** ______________

Pertinent PMHx:	**Extremity affected:**	**Side:**
☐ Numbness/Tingling	☐ Arm	☐ Right
☐ Pain	☐ Leg	☐ Left
☐ Weakness/Fatigue	☐ Other	☐ Bilateral

Please note: All patients will be tested for peripheral nerve entrapments, cervical or lumbar radiculopathy, and polyneuropathy in the limbs requested.

Comments:

Physician Signature: ______________________ **Date:** ______________

After completing this form, please call us for an appointment at 410-644-1880, EXT 2132.
Also, please bring a copy of this completed form with you.