



Neurodiagnostics/EMG Clinic  
 3101 Discovery Dr. Ste 300  
 Lansing, MI 48910  
 517-975-2935 Phone  
 517-975-2934 Fax

Patient Name:	Phone:
DOB:	Insurance:
BCN, BCN Advantage, Medicare BCN Global Auth OR VA Prior Auth Approval Info	
Auth Approval Number:	Dates Valid:

If Worker's Comp:	
Date of Injury:	Claim #
If Auto Accident:	
Date of Injury:	Open and Billable Claim #

REFERRAL FOR EMG	
Requested Exam:	Extremity to be examined:
<input type="checkbox"/> EMG/Nerve Conduction Study <input type="checkbox"/> Single Fiber <input type="checkbox"/> Other:	<input type="checkbox"/> Right <input type="checkbox"/> Arm <input type="checkbox"/> Left <input type="checkbox"/> Leg <input type="checkbox"/> Bilateral <input type="checkbox"/> Other:
Diagnosis with ICD 10: (Please circle)	Patient Instructions:
<ul style="list-style-type: none"> <li>Peripheral Polyneuropathy G62.9</li> <li>Carpal Tunnel Syndrome G56.01, G56.02, G56.03</li> <li>Stenosis</li> <li>Radiculopathy M54.10</li> <li>Neuropathy G62.9</li> <li>Myasthenia Gravis G70.00</li> <li>Other (Please describe with DX code):</li> </ul>	<ul style="list-style-type: none"> <li>No oil or lotion on extremity(s) being tested.</li> <li>Wear short/sleeveless shirt for upper extremity EMG.</li> <li>Wear or bring shorts for lower extremity EMG.</li> <li>Gowns are available.</li> <li><b>FAX EMG REFERRAL TO 517-975-2934</b></li> </ul>

Office Name:	Office Fax #
Physician Name:	
Physician Signature:	Date: