



NORTH SHORE MEDICAL CENTER

NSMC NEURODIAGNOSTIC TESTING REQUEST FORM: (EMG/EEG/ENG/NCV/EP)

- ◆ NSMC Salem Hospital fax to 1.978.740.4880 or call 978.354.4334
- ◆ NSMC Union Hospital fax to 781.477.3996 or call 781.477.3417

PT NAME: _____

DOB: _____ SS# _____

ADDRESS: _____

HOME PH# _____ WORK PH# _____ CELL _____
(if appointment is to be scheduled by someone other than above)

CONTACT NAME & TEL# _____

PRIMARY INSURANCE: _____ ID# _____

SUBSCRIBER: _____ RELATIONSHIP: _____

SECONDARY INSURANCE: _____ ID# _____

SUBSCRIBER: _____ RELATIONSHIP: _____

WORKERS COMPENSATION INFORMATION:

INSURANCE COMPANY: _____

ADDRESS: _____

PERSON HANDLING CASE: _____ PH # _____

CLAIM # _____ ACCIDENT DATE: _____

PLEASE CHECK REQUIRED TEST:

ELECOMYOGRAPHY (EMG/NCV)

UPPER ___ LOWER ___

RT ___ LT ___ BOTH ___

ELECTROENCEPHALOGRAPHY (EEG)

- () WAKING
- () SLEEP

EVOKED POTENTIALS (EP)

() VISUAL () AUDITORY

() SOMATOSENSORY () ARMS () LEGS

ELECTRONYSTAGMOGRAPHY (ENG)

()

REASON FOR TESTING _____

ORDERING PHYSICIAN: _____ PH# _____ FAX# _____

PRIMARY PHYSICIAN: _____ PH# _____ FAX# _____

ORDERING MD SIGNATURE _____

DATE OF EXAM _____ (TO BE ASSIGNED BY NEURODIAGNOSTIC STAFF)