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NERVE CONDUCTION STUDIES REFERRAL FORM

Patient Name: _____ DOB: _____ Gender: _____

Patient Address:_____

Best contact number: _____ Patient email: _____

FOCAL PROBLEMS					
UPPER EXTREMITY	***Right***	***Left***	***LOWER EXTREMITY***	***Right***	***Left***
Cervical radiculopathy			Lumbosacral radiculopathy		
Carpal Tunnel Syndrome (CTS)			Lumbar canal stenosis		
Median Neuropathy (except CTS)			Femoral Neuropathy		
Ulnar Neuropathy			Peroneal Neuropathy		
Radial Neuropathy			Sciatic Neuropathy		
Brachial Plexopathy			Tarsal Tunnel Syndrome		
Thoracic Outlet Syndrome			Lumbosacral Plexopathy		
Other upper limb neuropathy			Other lower limb neuropathy		
			OTHER		
			Facial Neuropathy (Bell's Palsy)		
GENERALISED PROBLEMS					
Peripheral Polyneuropathy (e.g. diabetic, CIDP, CMT etc)			Myasthenia Gravis		
Motor Neuron Disease (e.g. ALS etc)			Myopathy		
ADDITIONAL REFERRAL DETAILS (IF REQUIRED):					

Referring Doctor Name: _____

Provider Number:_____

Signature:_____**Date:**_____

Once completed, please send the referral to – medical objects, fax, email

A copy of the referral form can be found at www.drjoelpetre.com.au

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