Humber River Health
Lighting New Ways in Healthcare™

EMG Requisition

Neurodiagnostics Clinic

1235 Wilson Avenue (Keele & Wilson)

Portal of Care B, Level 1

Appointment Date:_____ **Time:**_____

Physician (check one):

☐ **Dr. D. Morgenthau**

☐ **Dr. Y. Jiang**

☐ **Dr. A. Patterson**

Phone: 416.242.1000 x 47202

Fax: 416. 242.1066

☐ **Dr. R. Magder**

Phone: 416.614.8711

Fax: 416.614.7566

Patient Name:_____ DOB: (date/mm/year)_____

HCN:_____ Version:_____

Address:_____ Postal Code:_____

Phone: (Home):_____ (Cell):_____

Examination Requested (please check one):

☐ Consultation, EMG and Management

☐ EMG only

Reason for referral:

_____

_____

_____

Ref Physician:_____ Billing Number:_____

Phone:_____ Fax:_____

Signature:_____ Additional Copy to:_____

Instructions: Please NO hand cream or body lotion and wear loose clothing