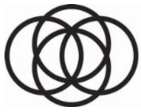 William Osler Health System

EMG/EEG

Department of Neurodiagnostics
Request for Electromyogram/Nerve Conduction Studies
Request for Electroencephalography/Evoked Potentials/EEG

☐ **Brampton Civic Hospital**
Tel.: 905-494-2120 Ext.57607
Fax: 905-494-6475
North Building, 2nd Floor

☐ **Etobicoke General Hospital**
Tel.: 416-747-3469
Fax: 416-747-3344
Lower Level, West Tower
'Outpatient Diagnostics'

Name: ___________________________
Address: ___________________________
____
City: ___________________________
Postal Code: ___________________________
Health Card No.: ___________________________
Date of Birth: (DD/MM/YYYY): ___________________________
Telephone #: ___________________________
Cell #: ___________________________

EMG / NERVE CONDUCTION STUDY

☐ Consultation with the EMG and Nerve Conduction Study
☐ Single Fibre/Consult

PLEASE INDICATE PHYSICAN PREFERENCE:

Brampton
☐ Dr. G. Tullio ☐ Dr. D. Dodig ☐ First Available
☐ Dr. M. Angel ☐ Dr. R. Rasquinha

Etobicoke
☐ Dr. D. Dodig ☐ Dr. L. Safinia
☐ Dr. R. Yufe ☐ First Available

Diagnosis and Clinical Information: (MUST BE INCLUDED)
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____
____

PATIENT INSTRUCTIONS:
Duration of the test varies, plan for at least 1 hours. You must bring a valid **ONTARIO HEALTH CARD** or if this is a work related injury, bring a **WSIB CLAIM NUMBER**. Please **do not apply** cream, oil or hand sanitizer on the skin or area being tested.

Etobicoke Site: You must register on the main floor 15 minutes before your appointment time.
Please call (416) 747-3469 **(2) days before** your appointment to confirm the date and time. ***Location: Lower Level Rm 060***

Brampton Site: Letters will be mailed with appointment date, time and test instructions.
Location: 2nd Floor, North Building, Cardiorespiratory

EEG

☐ Routine
☐ Sleep Deprived

EVOKED POTENTIALS (EP)

☐ Auditory Brainstem Response
☐ Full field visual Evoked Potentials
☐ Somatosensory Upper Limbs
☐ Somatosensory Lower Limbs

Clinical Information and reason for study: (MUST BE INCLUDED)
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____
____

Medications: ___________________________
____

Physician Name (Print) ___________________________ OHIP Billing # ___________________________

Physician Signature ___________________________ CPSO # ___________________________

Telephone___________________________ Facsimile___________________________ Date ___________________________

Copies to: (Physician Name) ___________________________

NOTE: INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN DELAY OF BOOKING.
Form # 8100-711-Rev. 21_08_2020