

## Patient details

Mr Mrs Miss Dr Other (please specify)	GP
First name	Practice
Surname	Address
Date of birth	Male / Female
Tel home	Mobile
Email	Tel
Address	Self pay / Insured
	Insurers name
	Policy number
Postcode	

## Test required

### EMG / Nerve Conduction Studies

- EMG / Nerve conduction studies (NP1004)
- Facial EMG / NCS (NP1004)
- Repetitive stimulation (NP1004)
- Single fibre EMG studies (NP1004)

### EEG Studies

- EEG – routine (NP1000)
- EEG – sleep deprived (NP1001)
- Prolonged EEG .....hrs [max = 4 hours] (NP1022)

### Evoked Potential Studies

- VEP – pattern, full field (NP1008)
- VEP – flash (NP1008)
- SSEP - upper limb (NP1010)
- SSEP - lower limb (NP1010)
- BSAEP (NP1009)
- Triple EPs [VEP,UL+LL SSEP & BSAEP] (NP1011)

## Clinical Information / Provisional Diagnosis (including medication):

## Referring clinician's details

Mr Mrs Miss Dr Other (please specify)	How would you like to receive the report? <input type="checkbox"/> Fax <input type="checkbox"/> Email <input type="checkbox"/> Post
Referrer name	Do you want the report sent to another clinician? If yes give details:
Specialty / profession	
Hospital / practice	Signature _____ Date _____
Address	
City                                      Postcode	
Email	
Tel    Fax	
Emergency contact no.	