Neurophysiology Referral Form

Patient details

Mr Mrs Miss Dr Other (please specify)

First name

Surname

Date of birth | Male / Female

Tel home | Mobile

Email

Address

Postcode

GP

Practice

Address

Tel

Self pay / Insured

Insurers name

Policy number

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)

Referrer name

Specialty / profession

Hospital / practice

Address

City | Postcode

Email

Tel | Fax

Emergency contact no.

How would you like to receive the report?

☐ Fax ☐ Email ☐ Post

Do you want the report sent to another clinician?

If yes give details:

Signature | Date

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