BLACKROCK HEALTH
HERMITAGE CLINIC

Hermitage Clinic

EMG / NERVE CONDUCTION REQUEST FORM

EMG/NCS ☐ **CTS/NCS** ☐

Name of Referrer: (pls print) _____

Patient Name: _____

Address: _____

Phone: *Home:* _____ *Mobile:* _____

Name of GP: _____

Hospital No: _____ Date Of Birth: ___/___/____

Insurance: VHI ☐ **AVIVA** ☐ **LAYA** ☐ **GLO** ☐ **OTHER** ☐

Insurance No: _____ Self Pay: ☐

Symptoms: ***(Pls give adequate information and write in BLOCK LETTERS)***

_____

_____

_____

Clinical Question: _____

Duration of Symptoms: _____

SITE: **ARM:** **Left:** ☐ **Right:** ☐ **Both:** ☐

LEG: **Left:** ☐ **Right:** ☐ **Both:** ☐

Anticoagulation: Yes ☐ No ☐

Signed: _____ Date: _____

Hermitage Medical Clinic, Old Lucan Road, Dublin 20
Tel: 01 6459292 **Email: neurophysiology@hermitageclinic.ie**