Email: reception@melbnc.com.au
Phone: 1300 080 784
Fax: 03 9111 0171
Healthlink EDI: mneuroca

NEUROPHYSIOLOGY REQUEST FORM

PATIENT DETAILS

Name …… DOB ……

Address ……

Phone ……

TEST/S REQUIRED

☐ EMG/NCS
☐ Single fibre EMG (Myasthenia)
☐ Blink responses
☐ Consult Needed
☐ Small fibre testing
☐ Repetitive stimulation
☐ Other

☐ EEG (30 – 60 mins)
☐ Sleep deprived (1.5 hrs)
☐ Prolonged EEG (up to 3hrs)

CLINICAL NOTES

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REFERRING DOCTOR

Name……

Address……

Provider no. ……

Signature …… Date……

*****Patient is to bring the original referral to the appointment. *****
*****Please ask patients not to apply moisturiser and remove jewellery on the test areas for the test. *****