EMG AND EVOKED POTENTIAL LABORATORY / AUTONOMIC TESTING LABORATORY REFERRAL REQUEST FORM

REFERRING PHYSICIAN INFORMATION

Referring Physician Name	NPI	Date (MM/DD/YYYY)
Practice Name	Referring Physician Email	
Office Street Address	City	State, Zip Code
Phone	Fax	Primary Care Physician

PATIENT INFORMATION

Medical Record #	Patient Name (Last, First, Middle)	Sex ☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)	Last four digits of SSN	Patient E-mail address
Street Address	City	State, Zip Code
Home Phone	Alternate Phone	
Parent Name (if minor)	Insurance Company	Policy Number
Will patient need an interpreter? Language?	Date of last NCVS/EMG test	

PATIENT INFORMATION

EMG/Evoked Potential Tests:

- ☐ Nerve Conduction Velocity (NCVS)
- ☐ Needle Electromyograph (EMG)
- ☐ Repetitive Nerve Stimulation (Jolly)
- ☐ Single-Fiber EMG
- ☐ Evoked Potential Study: (please circle)
  BAEP SEP VEP
- ☐ Other: ______________________

Autonomic Tests:

- ☐ Heart Rate Deep Breathing
- ☐ QSART
- ☐ Valsalva Maneuver
- ☐ TST (Sweat Chamber)
- ☐ ARS Head-Up and Tilt Table Test

List clinical question to be answered. Please submit any pertinent medical records.

Indication or Diagnosis: ____

Does patient have a pacemaker or defibrillator, or are they on a blood thinner? ☐ YES ☐ NO

This form collects information that is not part of the medical record. FOR LOCAL STORAGE ONLY.
Thank you for referring your patient to UAB Medicine!

CONTACT INFORMATION

- **Scheduling –** Phone: 205.934.2122 or 205.975.2468 • Fax: 205.934.3896
- **Insurance verification –** Phone: 205.975.3784

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