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EMG / NCS ORDER FORM

(CIRCLE ALL THAT APPLY)

UPPER:	**LEFT**	**RIGHT**	**BILATERAL**
LOWER:	**LEFT**	**RIGHT**	**BILATERAL**

Patient Name: _____

DOB: _____ **Patient Phone:** _____

Patient Insurance(s): _____

Diagnosis Code (ICD-10): _____

R/O: _____

Ordering Physician: _____

Ordering Facility: _____

Phone: _____ **Fax:** _____

Office Email: _____

Ordering Physician Signature: _____

AUTHORIZATION NUMBER:	
AUTHORIZATION DATES:	

In order for this EMG to be scheduled, please fax this form along with most recent office visit notes, patient demographics, and patient private insurance information, or work comp billing information. Once scheduled, you will be notified of the patient's appointment date and time.

For any other questions, please feel free to contact Dr. Sisler's procedure scheduler, at EMGREFERRAL@AOOK.COM or at (918) 927-3301.