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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.*