



NEURON MEDICAL CORP.  
[www.neuronmedical.com](http://www.neuronmedical.com)

227 West Janss Rd #135  
Thousand Oaks, CA 91360  
Phone 805-373-2890  
Fax 1-800-746-3510

For convenient scheduling, please call 805-373-2890  
or fax your request form to our toll-free fax 1-800-746-3510.

Patient name: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Referring physician phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for referral, diagnosis, symptoms: \_\_\_\_\_

\_\_\_\_\_

**PLEASE SEND PATIENTS INSURANCE INFORMATION WITH THIS FORM**

- Electrodiagnostic consult:
  - Consultation with physician to see the patient
  - Any required pre-certs will be obtained and appropriate test scheduled if needed
  - Physician will report finding and help implement a treatment plan.

Neuromuscular assessment:	<u>Right</u>	<u>Left</u>	<u>Both if needed</u>
<input type="checkbox"/> EMG/Nerve conduction legs	_____	_____	_____
<input type="checkbox"/> EMG/Nerve conduction arms	_____	_____	_____
<input type="checkbox"/> Blink reflex			_____
<input type="checkbox"/> Repetitive nerve stimulation (ex.- for myasthenia gravis)	_____	_____	_____

- EEG assessment
- EEG-routine
  - EEG-sleep-deprived
  - EEG- 24-hr ambulatory (similar to Holter for cardiac workup, to clarify syncopal or seizure episodes)
  - EEG- 48 hr ambulatory (similar to Holter for cardiac workup, to clarify syncopal or seizure episodes)

- Symptoms:
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Back injury        | <input type="checkbox"/> encephalopathy       | <input type="checkbox"/> sciatica/lumbago    |
| <input type="checkbox"/> back pain          | <input type="checkbox"/> foot drop/wrist drop | <input type="checkbox"/> syncope             |
| <input type="checkbox"/> back surgery       | <input type="checkbox"/> limping              | <input type="checkbox"/> twitching sensation |
| <input type="checkbox"/> burning sensation  | <input type="checkbox"/> loss of balance      | <input type="checkbox"/> weakness            |
| <input type="checkbox"/> convulsions        | <input type="checkbox"/> muscle weakness      | <input type="checkbox"/> other _____         |
| <input type="checkbox"/> carpal tunnel      | <input type="checkbox"/> neck injury          |  |
| <input type="checkbox"/> diabetes           | <input type="checkbox"/> numbness             |  |
| <input type="checkbox"/> difficulty walking | <input type="checkbox"/> pain in limbs        |  |

Referring Physician  
Signature \_\_\_\_\_