

Nerve Conduction Studies

Requisition

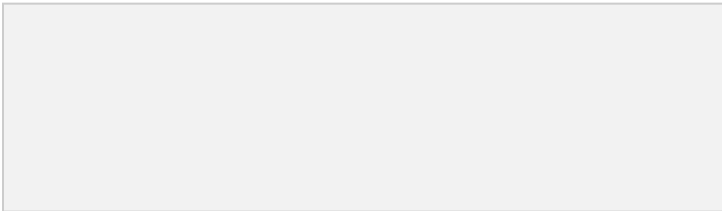
Name: _____ DOB (dd/mm/yyyy) _____

Address: _____ Sex: M F

_____ Health Card # & VC _____

Telephone (Home) _____

(Cell) _____



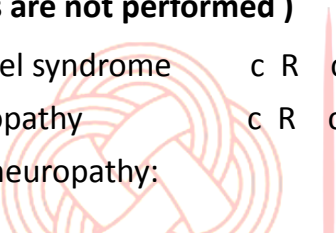
Please check off reason and Nerve to be tested:

(Needle studies are not performed)

Carpal tunnel syndrome c R c L

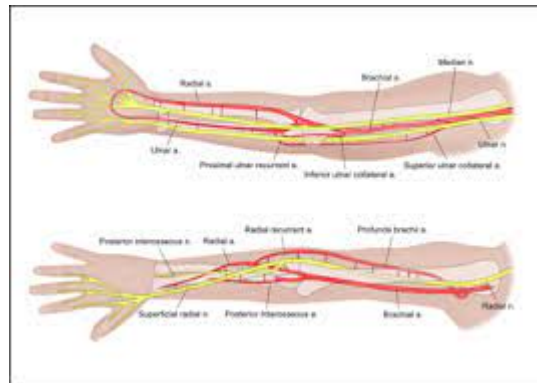
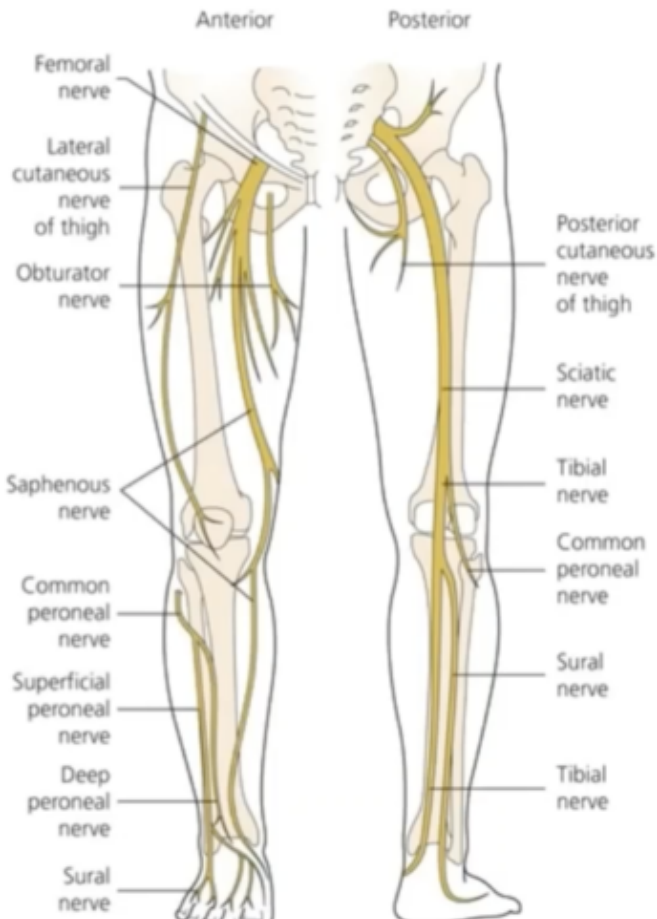
Ulnar neuropathy c R c L

Peripheral neuropathy:



Tele-N-Cephalon

Diagnostics Anywhere



Ordering Physician: (Please Print) _____

Billing #: _____

Fax #: _____

Date: _____

Signature: _____

Nerve Conduction Studies Requisition

Report Copies To: _____



Tele-N-Cephalon
Diagnostics Anywhere