Hartford HealthCare

Ayer Neuroscience Institute

EMG (MOB Suite 815)
Phone: (860)972-3621 Fax: (860)545-5003

Electromyography (EMG) Referral Form

Please Print Patient Information:

Name_____ DOB: _____Gender ❑ F ❑ M

Address _____ City _____ State _____ Zip _____

Phones: Home_____ Work_____ Cell_____

Emergency Contact _____

Phone_____

Insurance: _____ | Secondary Insurance _____

ID# _____ | ID#_____

Worker's Compensation_____

Worker's Compensation Contact _____ Phone _____

Claim/Authorization# _____ Date of Incident_____

Prior Authorization Required? Y / N **Authorization Number:**_____

CLINICAL SUMMARY:

Body Region: ❑Arm ❑Leg ❑ Cranial Nerve

Involved Site: ❑Right ❑Left ❑Both

Does the patient have a pacemaker? Y / N **Is the patient currently taking Anticoagulants Y / N**

List Medications:_____

_____

_____

Chief Complaint and Suspected Diagnosis *and* ICD-10 code:_____

_____

_____

Ordering Physician _____

Phone _____ **Fax** _____

_____ _____ _____

Physician Signature **Date** **Time**

PLEASE FAX FORM TO: (860) 545-5003