LOWCOUNTRY ORTHOPAEDICS
SPINE SPECIALISTS

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ELECTRODIAGNOSTIC STUDY REQUEST

PATIENT 'S NAME: _____

DATE OF REQUEST: _____

CHIEF COMPLAINT – RATIONALE STUDIES:

ELECTROMYOGRAM

UPPER	Arms and Neck	RUE	LUE
LOWER	Legs and Back	RLE	LLE

NERVE CONDUCTION

▪ **CTS** – MEDIAN AND ULNAR NERVE	RUE	LUE
▪ **ULNAR** – Neuropathy – Elbow	RUE	LUE
Wrist	RUE	LUE
▪ **RADIAL** Tunnel	RUE	LUE
▪ **PERONEAL** Neuropathy – Hip	RLE	LLE
Knee	RLE	LLE
▪ **PERIPHERAL POLYNEUROPATHY**	RUE	LUE
	RLE	LLE

OTHER STUDIES:

REFERRING PHYSICIAN: _____

WE WILL NEED LAST OFFICE NOTE, DEMOGRAPHICS AND INSURANCE INFORMATION
PLEASE CALL US DIRECTLY IF YOU NEED A SAME DAY APPOINTMENT OR IF YOU HAVE NOT HAD A RESPONSE FROM US WITHIN 24 HOURS.