



NORTHERN NEUROLOGY SPECIALTIES

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EMG/NCV REFERRAL FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ SEX: M ___ F ___

CITY: _____ STATE: _____ ZIP: _____

PHONE(H): _____ (W): _____ SS#: _____

INSURANCE CARRIER _____ ID# _____

DIAGNOSIS

- G56.0-CARPAL TUNNEL SYNDROME R L
 - G56.20-ULNAR NEUROPATHY R L
 - S14.3XXA-BRACHIAL PLEXOPATHY
 - S14.2XXA-CERVICAL ROOT Level? _____
 - G51.0-FACIAL PALSY
 - M21.379-FOOT DROP
 - M40.57-LUMBOSACRAL PLEXOPATHY
 - G54.4-LUMBOSACRAL ROOT Level? _____
 - G12.20-MOTOR NEURON DISEASE
 - G95.9-MYELOPATHY (spinal cord)
 - G72.9-MYOPATHY
 - G70.0-NEUROMUSCULAR TRANSMISSION DEFECT (eg. myasthenia gravis)
 - G60.9-PERIPHERAL NEUROPATHY
- _____ (OTHER) _____

ADDITIONAL INFORMATION:

PHYSICIAN: _____ DATE: _____

Phone: _____ Fax: _____

SIGNATURE: _____ NPI# _____

FAX NUMBER WHERE TEST RESULTS SHOULD BE SENT _____

NOTE: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK) WITH REFERRAL FORM.