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JILL A. BRESSLER, M.D.
BOARD CERTIFIED IN NEUROLOGY

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.