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| Referral Form for Neurophysiology Testing | |  |
| NCS/ EMG/ EP/ EEG/ IOM | | Dr Fahad Shaikh  Consultant in Clinical Neurophysiology |
| Tel: 07529 901 272 |
| Email: secretary@neurospark.co.uk |
|  | | |
| Patient Details |  | Referrer Details |
| Title: |  | Clinician Name: |
| First Name: |  | Speciality: |
| Last Name: |  | Hospital/Clinic: |
| CHI No/ DOB: |  | Clinician Email: |
| Gender: |  | Payment |
| Address: |  | ☐ Self-Funding |
| ☐ Insurance company \_\_\_\_\_\_\_\_\_\_\_\_\_  Policy number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Auth. number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Tel. Number: |  |
| ☐ Other (please provide details, e.g. UKS): |
| Patient Email: |  |
| Neurophysiological Investigation Required: | | |
| Present Clinical Problem and site of issue if relevant: | | |
| Relevant Past Medical/Surgical History: | | |
| Relevant imaging findings (e.g. MRI): | | |
| What information do you hope to obtain from this investigation? | | |
| Clinician Signature | | |
| Name in Print | | |
| Date | | |

Office use only NS Ref: