



114 Whitwell Street
Quincy, MA 02169
Tel: (617) 376-5710
Fax 617-376-2098

EMG REFERRAL FORM

*****THIS FORM MUST BE FILLED OUT COMPLETELY FOR VISIT TO BE SCHEDULED.*****

PATIENT INFORMATION:

Patient Name: _____

Address: _____

Home phone: _____ Cell phone: _____

SS#: _____ DOB: : _____ Sex: _____ Marital Status: _____

Language Spoken: _____ Interpreter Needed: _____ Yes _____ No

INSURANCE

Health Ins: _____ ID# : _____

If this is a Worker's Compensation claim, the approval letter from the Worker's Comp Insurance MUST be attached. If a referral is required we will send the request to the Primary Care's Office once an appointment has been scheduled. If you are not the PCP's office, please indicate the PCP in the space provided below.

We do NOT accept the following insurances:

One Call Medical, Motor Vehicle insurance, BMC Healthnet or Neighborhood Health

REASON FOR STUDY: _____

(Ex: right arm, rule out Neuropathy)

REFERRING PHYSICIAN: _____

Phone: _____ Fax: _____

PRIMARY CARE PHYSICIAN: _____

Phone: _____ Fax: _____

APPOINTMENT DATE AND TIME: (To be filled in be QMC Neurology Dept. Form will be faxed back to the referring physician's office when appointment is scheduled)

DAY: _____ DATE: _____ TIME: _____

Please fax any reports for tests done outside of QMC (MRI, X-Ray) to us at 617-376-2098 before patient's appointment. Thank you.