**Neurophysiology Service Referral Form**

Please send referrals to: **dgft.vfc.dudley@nhs.net**

(N.B. Incomplete request form may be rejected)

**Contact Number: 01384 456111 ext 2220**

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| --- | --- | --- |
| **Emergency Contact Number: 07422 934413** | | |
| **SECTION 1: PATIENT DETAILS** | | |
| **NHS Number:** |  | |
| **First Name:** | **Last Name:** | |
| **Date of Birth (DD/MM/YYYY):** | | |
| **Address (1st line):** | | |
| **Town / City:** | **Postcode:** | |
| **Tel. No. (Home):** | **Tel. No. (Mobile):** | |
| **Email Address:** | |

**PLEASE ENSURE YOU INCLUDE PATIENT’S TELEPHONE NUMBERS AS WE WILL CONTACT PATIENT BY PHONE**

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| --- | --- | --- | --- | --- |
| **SECTION 2: REFERRING GP’S DETAILS (PLEASE PRINT)**  **Please ensure you provide a valid Email Address to receive reports.** | | | | |
| **First Name:** | **Last Name:** | | | |
| **Practice address**  **Contact Tel. No.:**  **Please Email Reports To:**  + [dgft.neurophysiology@nhs.net](mailto:dgft.neurophysiology@nhs.net) | | | | |
| **SECTION 3: TEST SERVICE REQUEST** | | | | |
| **Medication:** | | | | |
| **Does the patient have an infection or do they pose an infection risk to others?** | * Yes | | * No | |
| **TEST REQUESTED: (please tick one only)** | | | | |
| * **EEG** | | | | |
| * **Nerve Conduction Studies** (Please complete Section 4) | | | | |
| * **EMG** (Please complete Section 4) | | | | |
| **Provisional Diagnosis:** | | | | |
| **Reason For Request:** | | | | |
| **Relevant Clinical History (PLEASE COMPLETE IN ALL CASES):** | | | | |
| **SECTION 4: COMPLETE FOR ALL NERVE CONDUCTION SCREENING OR EMG REQUESTS** | | | | |
| 1. **Is the patient a child?** | | * YES | | * NO |
| 1. **Does the patient have a cardiac pacemaker/implantable defibrillator?** | | * YES | | * NO |
| 1. **Is the patient on Warfarin or any anti-coagulation medication?** | | * YES | | * NO |
| 1. **Does the patient have classic ‘barn-door’ CTS symptoms, without any ulnar nerve involvement?** | | * YES | | * NO |
| 1. **Has the patient had CT decompression within last 6 months?** | | * YES | | * NO |
| 1. **Does the patient have inconclusive MRI scan result for radiculopathy with possible motor weakness?** | | * YES | | * NO |
| 1. **Does the patient have peripheral neuropathy with known diabetes or vitamin B12 deficiency?** | | * YES | | * NO |
| 1. **Does the patient have Meralgia Paraesthetica?** | | * YES | | * NO |

***If you have answered ‘yes’ to any of the questions 2 to 8, it is unlikely you have met our referral criteria. However, please ensure that you include any relevant information in the clinical history section to assist us in our triaging process.***

**Print & Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**