**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**

|  |
| --- |
| **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**

|  |
| --- |
| **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  |
| **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**