



Rutland Regional Neurology Center

A Department of Rutland Regional Medical Center

Erica Sweet, DO

Order/Request for Electromyogram (EMG) / Nerve Conduction Velocity (NCV) Testing

Patient Information:

Name: _____

DOB: _____ Male Female Contact Phone: _____

Insurance: _____

Diagnosis: _____

Detail of Symptoms: _____

Please circle below:

Test(s) Requested	Upper Extremity	Lower Extremity
EMG	Right	Right
EMG	Left	Left
EMG	Bilateral	Bilateral
Anticoagulant Medication _____	Yes	No
Pacemaker	Yes	No
Defibrillator	Yes	No

Date/Time

Physician Name

Physician Signature

➔ Fax to 802.747.6561

Fax results to: _____

Form #4729 1.16, 9.18



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Patient Label