DR RON GRANOT

East Neurology
Holistic Neurological Care

REFERRAL FORM

neurol.news/referral

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www.eastneurology.com.au/contact/

MAP:

PATIENT DETAILS

NAME: _____ DOB: ____/____/____

NERVE CONDUCTION / EMG

HAND

- ☐ CARPAL TUNNEL
- ☐ RADICULOPATHY (Specify: _____)
- ☐ ULNAR NEUROPATHY
- ☐ RADIAL NERVE (eg wristdrop)

SHOULDER AND ARM

- ☐ AXILLARY NERVE (DELTOID)
- ☐ SUPRASCAPULAR NERVE
- ☐ MYOPATHY
- ☐ MUSCULOCUT NERVE (Biceps)
- ☐ ACCESSORY N. to TRAPEZIUS
- ☐ BRACHICAL PLEXOPATHY

FEET AND LEG

- ☐ PERIPHERAL NEUROPATHY
- ☐ TARSAL TUNNEL SYNDROME
- ☐ PERONEAL N (Footdrop)
- ☐ SAPHENOUS NERVE

THIGH

- ☐ LAT. FEMORAL CUT. N (MERALGIA)
- ☐ POST. FEMORAL CUTANEOUS
- ☐ FEMORAL NERVE (QUADRICEPS)
- ☐ MYOPATHY

NEUROMUSCULAR

- ☐ ELECTROMYOGRAPHY (EMG)
- ☐ REPETITIVE N. STIMULATION

OTHER: specify _____

INFORMATION for PATIENTS:
NERVECONDUCTION.COM.AU

+ NEUROMUSCULAR ULTRASOUND

- ☐ add ULTRASOUND (AS APPROPRIATE) IN CONJUNCTION WITH ABOVE

EEG

- ☐ ROUTINE EEG
- ☐ SLEEP DEPRIVED EEG

INFORMATION for PATIENTS:
BRAINWAVETEST.COM.AU

REFERRING DOCTOR

NAME: _____ PROV NO: _____

DATE: ____/____/____ SIGNED: _____