WRHN
Waterloo Regional Health Network

EMG TESTING CLINIC
Physical Medicine and Rehabilitation Outpatient Referral Form

WRHN @ Chicopee, Pioneer Terrace 1st Floor
3570 King Street East, Kitchener, Ontario, N2A 2W1
Phone: 519-749-4300, ext. 7860 Fax: 519-894-8310

Patient's Last Name:	**Patient's First Name:**	**Initial:**	❑ Male □ Female ❑ Other_____
DOB (year/month/day):	**Health Card #:**	**Version Code:**	**WSIB Claim #:**
Street Address:	**City:**	**Province:**	**Postal Code:**
Patient's Phone:	**Cell Phone:**	**The patient consents to messages being left at this number ❑ Yes ❑ No**	

Services Requested:

❑ EMG	❑ EMG with Consultation

History:

Reason for Referral:

Additional Comments:

To ensure the most appropriate intervention, please include relevant operative reports, consult notes, imaging results, and rehabilitation therapy reports (unless available through Clinical Connect).

Referring Physician Name (please print):	**Physician's Phone #:**	**Physician's Fax #:**
Physician's Signature:	**Physician's Billing #: (Required)**	

Revised: 15 FEB 2024