THE LONDON CLINIC

Neurophysiology request

PATIENT INFORMATION

*indicates mandatory fields

*TLC unit no. (if known) L

*Title

*DOB dd/mm/yyyy)

*Surname

*Forename(s)

*Gender M F

IP OP DC

Room

*Referrer's full name and / or practice stamp

Payment method ☐ Insurance ☐ Embassy ☐ Self-Pay ☐ Sponsor

Payment provider

Member no.

Authorisation no.

Patient's tel no.

Patient's email

Patient's address

Copy of reports to

CLINICAL INFORMATION

Infectious:	Yes ☐ No ☐
If yes, Barrier nursed:	Yes ☐ No ☐
Oxygen required:	Yes ☐ No ☐
Mode of transport:	Walking ☐ Wheelchair ☐ Bed ☐ Portable ☐
Date & time of appointment	

N.B. This form is a legal document – Referrer's Declaration

- The correct patient details have been provided.
- I have discussed the examination, including any intervention, with the patient / guardian.
- I have taken into account the possibility of pregnancy
- I have given sufficient clinical information for the request to be justified according to IR(ME)R 2017.
- I will ensure that the examination results are recorded in the patient's notes.

***Clinical indication for examination.** Please summarise relevant history, clinical findings, previous imaging and test results. Indicate the question that the examination should answer.

Date of previous EMG ____/____/____

Preferred Clinical Neurophysiologist:

Examination requested	
EEG Electroencephalogram	☐
EEG - Sleep deprived Electroencephalogram	☐
EEG - Video recorded Electroencephalogram	☐
SF EMG Single Fibre Electromyography	☐
EMG Electromyography	☐
NCS 1 - 2 Limbs Nerve Conduction Studies	☐
NCS 3 - 4 Limbs Nerve Conduction Studies	☐
EMG + NCS Electromyography Nerve Conduction Studies	☐
EMG + NCS (Portable) Electromyography Nerve Conduction Studies	☐
VEP Visual Evoked Potential	☐
BSEP Brain Stem Evoked Potential	☐
UL - SSEP Upper Limb Somato Sensory Evoked Potential	☐
LL - SSEP Lower Limb Somato Sensory Evoked Potential	☐

Referrer's signature _____ Date ____/____/____

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