10003-24th St. SW, T2V 5K3
Tel: (587) 481-7866
Fax: (587) 481-7877
www.southlandemg.com

PATIENT INFORMATION (can use label)

Name:_____ Gender:_____

Date of Birth:_____ PHN: _____

Address:_____

Phone: (H)_____ (W)_____

REFERRAL INFORMATION

Priority: Urgent Routine

Urgent requests must be discussed by direct consultation with Dr. Mrkobrada

Referring practitioner

Name:_____

Phone:_____ Fax:_____

PRACID:_____

Clinical question

Musculoskeletal problem (specify area)

Neck
Shoulder
Wrist
Back
Hip
Knee

Other Physiatry consult (please specify):

Clinical information (please attach previous EMG studies, consults, relevant imaging, bloodwork and medications)

Past medical history

Diabetes
Thyroid disease
HIV or Hepatitis C
Alcohol abuse

Other:

Is the patient on anticoagulation: Yes No

Signature: Date:

Please fax completed form to Southland EMG, fax # (587) 481-7877