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:_____

Injectables:

Anaesthetic Side: Left Right
Corticosteroids
Other (please specify):

Peripheral procedures:

Wrist: Carpal tunnel
First extensor compartment
First CMC joint

Shoulder: Subacromial bursa
Long head biceps tendon
Glenohumeral joint

Elbow: Lateral epicondylitis
Medial epicondylitis

Trigger point
specify area:

Other (please specify):

Patient details

Allergies:

Pregnant: Yes No

Medical history - *please attach all relevant medical history*

Diabetes:

HIV or Hepatitis C:

Is the patient on anticoagulation: Yes No

Signature: Date:

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