

CALIFORNIA SPORTS AND REHAB

ELECTRODIAGNOSTIC STUDIES

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Email: referral@emg-ncv.com

Patient's Name: _____

Appointment Date: _____ Time: _____

() **EMG** / () **NCV**

() **Upper Extremities**

() **Lower Extremities**

Upper

Median R L

Ulnar R L

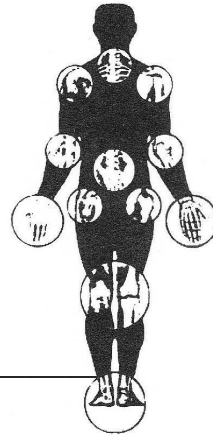
Radial R L

Lower

Peroneal R L

Sural R L

Tibial R L



() **Neuromuscular Junction Study**

() **Other Studies** _____

Referring Physician: _____

Signature: _____

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