EMG Laboratory
SASKATOON CITY HOSPITAL
701 QUEEN STREET
SASKATOON, SK, CANADA S7K OM7
TEL (306)655-8175 FAX (306)986-7222

Saskatoon Peripheral Nerve Clinic Referral Form

PATIENT INFORMATION

First Name:	Last Name:	Sex:
Date of Birth (MM/DD/YYYY):	Personal Health Number:	
Street Address:		
City:	Postal Code:	
Phone:	☐ WCB #:	☐ SGI #:

REFERRAL INFORMATION

Date of injury: (Note: it is best for patient outcomes if we can assess them within 3 months of nerve injury)

Body region of injury:

Reason for consultation: Please refer patients with peripheral nerve issues who you feel may benefit from multidisciplinary assessment and potential nerve surgery. Below are common conditions currently seen in clinic.

☐ Brachial Plexus injury/Brachial Plexopathy
☐ Traumatic upper extremity nerve injury
☐ Radial/PIN/AIN/high median neuropathy
☐ Severe ulnar neuropathy considering AIN nerve transfer
☐ Upper extremity nerve tumors (eg. Schwannoma)
☐ Other: _____

* Acute penetrating nerve trauma (e.g., lacerations) – please refer to on-call surgeon for immediate management *

History (please attach previous consults)**:**

Previous Interventions and investigations (please attach previous EMG studies, consults, relevant imaging)

☐ MRSA ☐ Other contact precautions	Is the patient on anticoagulation? ☐ Yes ☐ No
Referring Physician: Address: Telephone: Fax:	Family Physician: Address: Telephone: Fax:

Referring Physician Signature: _____ Date: _____