NEUROMUSCULAR RESEARCH CENTER

www.nrcaz.com

K. SIVAKUMAR, MD

4545 E Shea Blvd, Suite # 175, Phoenix, AZ 85028
Phone 480 314 1007 Fax 480 314 1003

CONSULT & EMG/NCS REQUEST FORM

Patient Name _____

Address _____

City _____State _____ Zip_____

Home Phone _____ Work/Other _____

Date of Birth _____ Social Security_____

Insurance Information

Insurance Name _____ Group #_____

Authorization #_____ # Of Visits_____

Referring Office Information

Referring Physician
_____UPN#_____

Office # _____ Fax #_____

Form Completed by: _____

□ Symptoms / Problems / Diagnosis _____

REQUEST FOR:

□ EMG/NCS:

□ Arms

□ Legs □ Right □ Left □ Both □ Other

□ Consult & EMG/NCS as needed

□ Consultation

Important Requirements

Please read and check

An appointment will NOT be made without this information.

1. Completed consult and EMG/NCS request form (below) □
2. Relevant medical records and labs. □
3. If required by insurer referrals/authorizations. □