EMG / NCV Testing Referral Form

Blanchard Valley Medical Associates, Inc.

Dr. Carmela Osborne

Phone: (419) 425-8007 Fax: (419) 429-6484

Date of Referral: _____/_____/_____

Procedure or Testing Requested: _____

Referring Physician Name: _____

Referring Physician Phone: _____ Referring Physician Fax: _____

Patient's PCP: _____

Patient Demographic Information

Patient Last Name: _____

Patient First Name: _____ Patient Middle Initial: _____

Patient Date of Birth: _____/_____/_____

Patient Address: _____

Patient City: _____ Patient State: _____ Patient Zip: _____

Patient Phone: (*Please mark an X to indicate the preferred contact number.)*

❒ Home: _____ ❒ Cell: _____ ❒ Work: _____

Clinical Information

Reason for EMG / NCV (Diagnosis): _____

Please send the following required attachments with this Referral Form:

⇒ Office / progress notes related to need for EMG / NCV testing
⇒ Any prior x-ray reports
⇒ Any prior CT scan reports
⇒ Any prior MRI reports
⇒ Copy of insurance card(s) - Include front and back of primary and secondary (if applicable)

We do not accept Paramount or Molina insurance.

For a full list of insurances with whom we participate, visit bvma.com/for-our-patients/insurance-company-list

Fax completed form and required attachments to:
(419) 429-6484