Your good health is our goal!

Northern Physical Therapy

Electromyography Laboratory Authorization & Consent for Testing

Electromyography (EMG) and Nerve Conduction Testing (NCS) are patient services provided in response to a wide variety of medical conditions for patients of all ages, regardless of gender, color, race, creed, national origin or disability.

The purpose of EMG/NCS testing is to evaluate the neuromuscular system and to find diseases that damage the nerves, muscles or the junctions between the nerves and muscles (neuromuscular junction).

All procedures will be thoroughly explained to you. During the NCS, mild electric currents will be applied to the skin on parts of your body. This is done to assess how quickly impulses travel in nerves and the NCS testing may be repeated on several different nerves. The EMG assesses muscle function. A fine needle electrode will be placed under your skin into the muscle being tested. The needle measures the electrical activity in your muscles and it may be repeated on several muscles. You also will be asked to contract your muscle during the EMG.

There are certain inherent risks with EMG/NCS. During the EMG, you may experience some discomfort similar to an injection and may have some residual soreness and bruising for a few days. EMG may also cause false results on muscle enzyme laboratory test and muscle biopsies. There may also be other risks depending on your medical condition: please discuss those with your referring physician or with your electromyographer. During NCS testing, you may feel a shock like sensation as the nerve is stimulated even though the amount of voltage applied is very small. You may feel your muscles twitch. As with EMG testing, there may be other risk depending on your medical condition; please discuss those with your referring physician or with your electromyographer.

Based on the above information, I agree to cooperate fully and to participate in the procedure. I acknowledge that I have read this authorization and agree to be compliant. I acknowledge that I have had the procedures explained to me.

______________________________________________________
Patient Signature

______________________________________________________
Date

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____________________________________________________  __________________________________
Witness Signature                      Date

The patient is responsible to obtain prior authorization for Physical Therapy from Insurance. The patient is responsible for Deductibles and Co-payments at the time of service and any balances due after insurance has made payment.

**Patient Information**

Patient Name: _____________________________ DOB: __________ SS #: _____________________________

Ins. Subscriber’s Name: _____________________________ DOB: __________ SS# _____________________________

If a minor responsible Party Name: _______________________________________________________

Billing Address: _____________________________ City/State: _____________________________ Zip: __________

Home Phone: _____________________________ Work Phone: _____________________________ Cell Phone: _____________________________

Height: _____________________________ Weight: _____________________________

Email: __________________________________________

Is this a Workers Compensation Claim?: ___________ Car Accident?: _____________________________

Have you been covered under Home Healthcare?: ___________ If yes, date discharged: _____________________________

**For Active Duty Military Personnel Only:**

Commander’s Name and Rank: _____________________________ Phone# _____________________________

Unit: _____________________________

Sponsor’s SS#: _____________________________
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Patient Name: ___________________________ Date: _____________

Height: ___________________ Weight: ___________________

Present Status:

Please describe your symptoms (i.e. pain, numbness, burning, tingling, coldness, weakness, etc.)

____________________________________________________________________________________

When did your symptoms begin? __________________________________________________________

How frequently do you have your symptoms?

☐ Rarely (less than 10% of the day) ☐ Occasionally (11-25% ) ☐ Intermittently (26-50%)

☐ Frequently (51-75%) ☐ Constantly (76-100%)

Do you have a history of falls? ☐ Yes ☐ No

Do you drop things often? ☐ Yes ☐ No

Do your symptoms get better or worse at night? _____________________________________________

Please mark on the following diagrams where you have your symptoms:
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Medical History:

Do you have a history of the following medical conditions? (Check all that apply.)

- Heart Condition
- Coronary Artery Disease
- Peripheral Artery Disease
- Diabetes
- Pacemaker
- High Blood Pressure
- High Cholesterol
- Thyroid Disorder
- Stroke / CVA
- Cancer
- Chemotherapy
- Radiation Therapy
- Connective Tissue Disease
- Asthma
- Neck pain
- Lower back pain
- Disc Herniations
- Arthritis
- Stenosis
- Neuropathy
- Alcoholism
- Drug Use
- HIV / AIDS
- Hepatitis
- Other

Do you experience any of the following symptoms? (Check all that apply.)

- Fever
- Chills
- Weight gain
- Weight loss
- Fatigue
- Lack of appetite
- Headache
- Dizziness
- Fainting
- Shortness of breath
- Chronic cough
- Chest pain
- Palpitations
- Heartburn
- Abdominal pain or bleeding
- Joint pains or arthritis
- Balance or coordination problems
- Bladder or bowel incontinence
- Bleeding disorders or anemia
- Depression or anxiety

Are you a smoker?  □ Yes  □ No

Please list all medications you are taking: ___________________________________________________
____________________________________________________________________________________

Surgical History:

Do you have a history of the following surgeries? (Check all that apply.)

- Back Surgery
- Neck Surgery
- Joint Replacement
- Amputation
- CABG / Heart Surgery
- Angioplasty
- Removal of Mass / Cancer
- Other