THE NEUROLOGICAL CARE ENTER OF MONTGOMERY, PC
1315 MULBERRY STREET
MONTGOMERY, AL 36106
PHONE- 334-262-1113 FAX- 334-262-1119

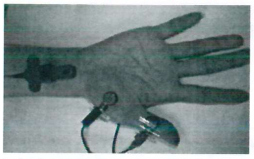
EMG/NCV Patient Screening & Consent

Dear patient:

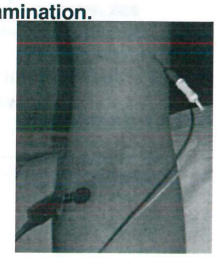
Your treating doctor has referred you to undergo specialized nerve testing to better evaluate your nerves & muscles for diagnostic purposes. The purpose of these procedures is to aid in the identification of the source(s) of your physical complaints. The information obtained by this testing will be used to help in making more accurate and specific diagnosis and help to guides regarding your condition.

Nerve Conduction Velocity (NCV):

This portion of the examination will test the speed of an impulse within a number of nerves in your arm/legs or both. Surface electrodes will be placed upon your skins surface in a number of strategic locations to record the information into the computer. A brief electrical tap will be administered at these locations causing certain muscles to twitch briefly. This test has no side effects and causes very little discomfort.



Electromyography (EMG): This portion of the examination will be able to evaluate the muscles directly and the nerves indirectly. This procedure involves placing a small sterile acupuncture like pin into some select muscles. You will experience only a small pinch during this examination.



GENERAL INSTRUCTIONS:

1. **Eat your normal meal.**
2. **Continue any medication you are taking unless otherwise instructed.**
3. **You may bathe or shower the morning of the test but DO NOT USE BATH OILS, OR SKIN CREAMS. If we need to investigate your face DON'T WEAR MAKE UP.**
4. **Please advise the doctor if you are on any prescription blood thinners.**
5. **PLEASE WEAR LOOSE FITTING CLOTHES for the examination as this will reduce the need for undressing.**

PLEASE COMPLETE BACK

EMG CONSENT

Patient Screening* * * * * please check the following which apply to you * * *

I have been diagnosed with Hepatitis:	**_____Yes**	**_____No**
I have been diagnosed with Diabetes:	**_____Yes**	**_____No**
I have been diagnosed with HIV:	**_____Yes**	**_____No**
I am taking Blood Thinner Medication:	**_____Yes**	**_____No**
I have had a Mastectomy/Lumpectomy	**_____Yes**	**_____No**
I have a Pace maker:	**_____Yes**	**_____No**
I am currently pregnant:	**_____Yes**	**_____No**

Authorization & Consent

I herewith authorize & request my attending doctor to perform Nerve conduction & electromyographic evaluation as he deems necessary or in exercise of their professional judgment. My attending doctor has explained to me the possible risks involved in the test(s) including potentional: soreness, bruising, bleeding, and infection. I am aware that I have the right to a second opinion and I have been given the opportunity to ask any questions that I may have had regarding this testing. I have read the above and give my consent to the above evaluations (EMG/NCV).

Patient Signature_____**Date**_____
Referring Physician:_____
Medications:_____
_____
Chief Complaint:_____