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INITIAL REFERRAL FORM

Patient

Name	
Address	
Date of Birth	
Gender	
Phone	
Fax	
E-Mail	
Place of Birth	
Ethnicity	
Employment	

Referring Physician

Name	
Address	
Phone	
Fax	
E-Mail	

Primary Care Physician

Name	
Address	
Phone	
Fax	
E-Mail	

Allergy to medication X-ray or Latex

Yes ◯ No ◉

Agent	Reaction

List and describe the nature and duration of your neuromuscular symptoms

1
2
3
4
5

List any other issues you may want us to know about

1
2
3
4

Date NRC

First Name Last Name

Memory Problems	Yes ◯	No ◉	Muscle pain / Cramps	Yes ◯	No ◉	Muscle wa:	Yes ◯	No ◉
Bad Headaches	Yes ◯	No ◉	Low back pain	Yes ◯	No ◉	Muscle we:	Yes ◯	No ◉
Fainting / Blackout	Yes ◯	No ◉	Neck pain	Yes ◯	No ◉	Muscle fati	Yes ◯	No ◉
Convulsions	Yes ◯	No ◉	Involuntary movements	Yes ◯	No ◉	Swallowing	Yes ◯	No ◯
Numbness in hands	Yes ◯	No ◉	Coordination problems	Yes ◯	No ◉	Speech diff	Yes ◯	No ◉
Numbness in feet	Yes ◯	No ◉	Balance problems	Yes ◯	No ◉	Breathing c	Yes ◯	No ◉
Visual Problems	Yes ◯	No ◉						
Other Symptoms								

Chest pains ?	Yes ◯	No ◉	Feet or leg swelling at end of day ?	Yes ◯	No ◉
Chest tightness when excited ?	Yes ◯	No ◉	Diagnosis of heart trouble ?	Yes ◯	No ◉
When walking or walking ?	Yes ◯	No ◉	Does heart thump or race ?	Yes ◯	No ◉
Other Sympoms:					

Skin rash	Yes ◯	No ◉	Frequent itching	Yes ◯	No ◉	Easy skinbruising	Yes ◯	No ◉
Other dermatological problems								

Heartburn	Yes ◯	No ◉	Indegestion or stomach trouble	Yes ◯	No ◉	
Colon Polyps	Yes ◯	No ◉	Frequently constipated	Yes ◯	No ◉	
Rectal bleeding	Yes ◯	No ◉	Frequent Diarrhea	Yes ◯	No ◉	
Stomach or duodonal ulcer	Yes ◯	No ◉	Other Gastro Intestinal trouble			
Gallbladder trouble	Yes ◯	No ◉				
jaundice	Yes ◯	No ◉				

Wake up more than once to urinate ?	Yes ◯	No ◉	Blood or pain urinating	Yes ◯	No ◉
Trouble starting urinating ?	Yes ◯	No ◉	Blood in the urine	Yes ◯	No ◉
Trouble emptying bladder ?	Yes ◯	No ◉	Passed a kidney stone in your urine	Yes ◯	No ◉
Treated for urine infection ?	Yes ◯	No ◉	Other symptoms		

Insomnia	Yes ◯	No ◉	Frequently nervous or upset	Yes ◯	No ◉
Ever had nervous breakdown	Yes ◯	No ◉	feel discouraged or depressed	Yes ◯	No ◉
difficulties in sex life	Yes ◯	No ◉	Other psychiatric problems		

Thyroid trouble	Yes ◯	No ◉	Other endocrine problems		
Taken These ?					
Hormone shots or pills	Yes ◯	No ◉			
thyroid medication	Yes ◯	No ◉			
insulin or diabetes medicine	Yes ◯	No ◉			
cortisone or similar	Yes ◯	No ◉			

Most recent sigmoidoscopic or proctoscopic examination				Normal ◯	Abnormal ◉
Vaccination History (Type and Date)		1		2	
3		4		5	

Women

Abnormal Pap smear	Last Pap smear	Last menstrual period
Recent Mammogram	Number of pregnancies	Number of miscarriages
Periods Regular ◯	Irregular ◉	

Date		NRC	
First Name		Last Name	

Please check the illnesses you have had before

☐ Asthma	☐ Bleeding disorder	☐ Cancer	☐ Diabetes	☐ Glacoma
☐ HIV	☐ Heart trouble	☐ Hepatitis	☐ High Blood Pressure	☐ Jaundice
☐ Kidney trouble	☐ Nervous disorder	☐ Sleep apnea	☐ Reflex or Peptic ulcer	
☐ Blood clots	☐ Stroke	☐ Tuberculosis	☐ Hypothyroidism	
☐ Other				

Please list past surgical procedures and year

Pocedure	Year	Procedure	Year

List and describe the nature and duration of your neuromuscular symptoms

	Medication	Dosage	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

	Alcohol	Tobacco	Drugs
Now	◯	◯	◯
Past	◯	◯	◯
Never	◉	◉	◉
Amount			
Years used			
Quit when			

Blood transfusion	Yes ◯	No ◉
If Yes when ?		

	Living		Present age / Age at death	Health Issues
Father	Yes ◯	No ◉		
Mother	Yes ◯	No ◉		
Spouse	Yes ◯	No ◉		
Brothers	**Living**		**Health issues**	
	Dead		**Cause of death**	
Sisters	**Living**		**Health issues**	
	Dead		**Cause of death**	
Children	**Living**		**Health issues**	
	Dead		**Cause of death**	
Comments				

For use by Physician only

Summary:

Reviewed old record Yes ◯ No ◉ Reviewed images Yes ◯ No ◉

Labs	Biopsy	X-ray/MRI	EMGS

Request for more info from:

Diagnosis:

1 2 3 4

Date NRC

First Name Last Name