

**CONSULT & EMG/NCS REQUEST FORM**  
**Neuromuscular Research Center**  
**K. Sivakumar M.D.**  
222 West Thomas Road suite 110A Phoenix, AZ 85013  
10200 N 92<sup>nd</sup> Street Suite 101 Scottsdale, AZ 85258  
(480) 314-1007 \* Fax (480) 314-1003

**PLEASE CHECK & FAX THE FOLLOWING INFORMATION.**  
**An appointment will NOT be made with out this information.**

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

Patient Name _____			
Address _____			
City _____	State _____	Zip _____	
Home Phone _____	Work/Other _____		
Date of Birth _____	Social Security _____		

**Insurance Information**

Insurance Name _____ Group # _____ ID# _____			
Claims Phone # _____	Authorization # _____	# of Visits _____	

**Referring Office Information**

<b>REQUEST FOR:</b>			
<input type="checkbox"/>	EMG/NCV	Upper Extremities or Lower Extremities	<b>Right / Left / Both</b>
<input type="checkbox"/>	Consultation	<b>Diagnosis?</b> _____	
<input type="checkbox"/>	Referring Physician	_____	UPIN# _____
	Office #	_____	Fax # _____
Form Completed by: _____			

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**WE THANK YOU FOR YOUR CONFIDENCE IN REFERRING PATIENTS TO US**

**We have two physical locations given on this letterhead.**

1. **Scottsdale office** will be open for New Patient Consults, Follow-up visits and Nerve conduction studies and electromyography (NCS/EMG).
2. **Phoenix office** will provide Nerve conduction studies and electromyography (NCS/EMG) services only.

**Requests for consultations and NCS/EMG services:**

1. Please **complete the attached form in its entirety** and fax it with **only the relevant medical records** to (480) 314-1003. This will avoid delays in scheduling.
2. If your patient wishes to be seen for **EMG/NCS tests in the Phoenix location** please make a note on the form.
3. If you are a specialist's office and the patient requires an authorization, please include this primary care physician's or Insurer's **authorization** also to avoid delays

***WE KNOW THAT YOU REALIZE THAT THE PATIENT'S AND THE PHYSICIAN'S TIME IS WASTED WITHOUT RELEVANT MEDICAL RECORDS OR AUTHORIZATION. TO AVOID CONFUSION AND DELAYS PLEASE FAX THE REQUEST WITH ALL THREE ITEMS MENTIONED ABOVE.***

**Your patients are welcome to contact us two days after your office has sent us the necessary information requested. Do not have your patients contact our office with out faxing us this form. No appointment will be scheduled without the information requested**

**If you provide your office e-mail address we will notify you that the appointment has been made. You are also welcome to contact me by e-mail to verify if we have received your fax.**

**Thank you in advance for referring your patients to our office.**

**Tina Winstead  
Scheduler  
Neuromuscular Research Center  
10200 N 92nd Street, Ste 101  
Scottsdale, Arizona 85258  
480-314-1007 X 1 / FAX 480-314-1003  
twinstead@nrcaz.com**