

# NEUROLOGY/NEUROPHYSIOLOGY REQUEST FORM

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Consultant Neurologist and Neurophysiologist  
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Sydney North Specialist Centre  
Level 2, 511 Pacific Hwy,  
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Provider No: 065320AT

Ph: 02 94675900  
Fax: 02 94675901

Patient:

Referring Dr:

D.O.B.:

Dr Address:

Referral Date:

Tel:

Fax:

Appointment Date:

Provider No:

Appointment Time:

Signature:

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**Service(s) Requested:** *(please tick)*

**Clinical Notes:**

**Consultation**

**Nerve conduction/EMG**

**EEG**

**Evoked potentials – VEP, SSEP, BAEP**

**Specify .....**

**Botulinum toxin treatment (hemifacial spasm; blepharospasm; cervical, laryngeal and other dystonia; migraine; spasticity; hyperhidrosis; hypersalivation)**

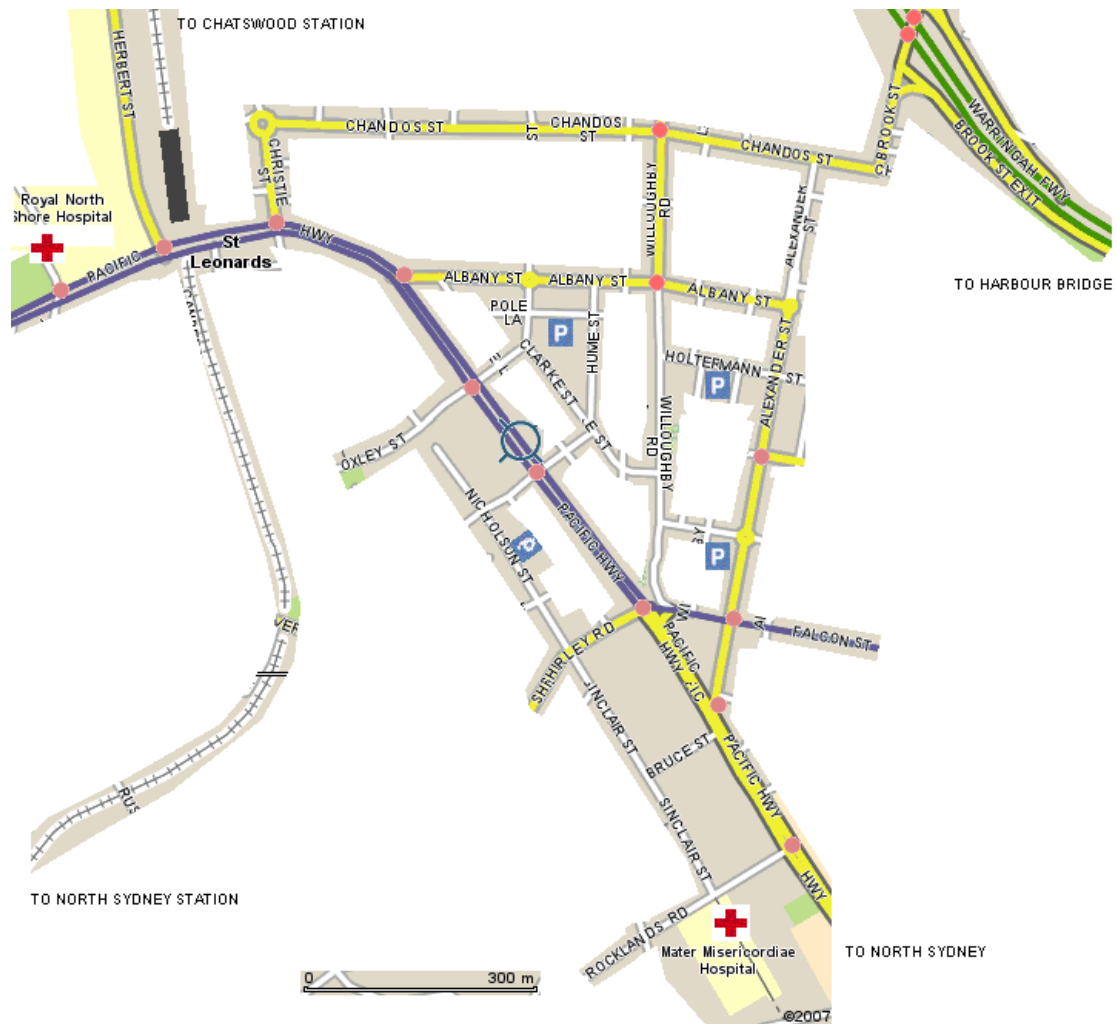
**My appointment date and time:**

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Further information on the tests and copies of this request form are available from:  
<http://www.virtualmedicalcentre.com/investigations.asp?sid=53>