

NORTHWEST NEUROSPECIALISTS PLLC
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Sarah E Sullivan DO

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Phone (520) 742-7890 * Fax (520) 742-7894

Patient Name: _____ Date of Birth: _____

Patient's Phone Number: _____ Insurance : _____

Policy#: _____ Group Number: _____
(Or attach a copy of patient's insurance card)

Insurance Authorization Number (if required) _____

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CONSULT ONLY _____ **EMG/NCV ONLY** _____

CONSULT and EMG _____

Chief Complaint: _____

Referring Physician: _____

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EVALUATE SPECIFICALLY FOR:

PERIPHERAL NEUROPATHY

CARPAL TUNNEL SYNDROME:	RT	LT	BILATERAL
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ULNAR NERVE ENTRAPMENT

RADICULOPATHY	CERVICAL	LUMBAR
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FOOT DROP

TARSAL TUNNEL SYNDROME	RT	LT	BILATERAL
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MYASTHENIA GRAVIS

RADIAL NERVE INJURY

SCIATICA

OTHER: (PLEASE SPECIFY)
