To: Community Neurologic Center

- ☐ Steven V. Lekah, M.D.
- ☐ John R. Wilson, M.D.

Date .....

Patient Name .....

Patient Address .....

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Patient Phone .....

Referral from Dr. .....

DX / Symptoms: .....

.....

.....

Please, check]

CONSULTATION ☐ **EMG / NCV** ☐ **EEG** ☐ **PSG** ☐ **BOTOX** ☐

POLYSOMNOGRAPHY

LEFT LEG ☐ **RIGHT LEG** ☐

LEFT ARM ☐ **RIGHT ARM** ☐

BOTH ARMS ☐ **BOTH LEGS** ☐

Please, FAX this FORM along with a COPY of PATIENTS INSURANCE CARD front and back

Call Dr. Lekah's office to schedule your appointment
Tel. 630-208-7735, Fax: 630-208-6956

Community Neurologic Center
2401 Kaneville Rd., Suite 8, Geneva, IL 60134
www.neuro-clinic.com

I certify that I am ordering specified services for the above named patient. I, as the ordering physician for services described in this request, certify that to my best knowledge, that the tests and any interpretation required is medically necessary in order to provide information which will assist in the proper diagnosis and/or treatment management for the above named patient. I understand that the tests ordered, and any interpretation, that I receive are intended to supplement my diagnosis of this patient's condition.

White: Doctor's Copy,
Yellow: Patient's Copy

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Signature