# UT Erlanger Neuromuscular Medicine

*Electrodiagnostic Laboratory*
*Reporting of Results*

Please complete the following to ensure that results are communicated to your health care team:

When are you scheduled for follow up with your referring provider?

_____

Referring Provider: _____

Phone# _____

Fax# _____

Primary Care Physician: _____

Phone# _____

Fax# _____

Additional Provider: _____

Specialty _____

Phone# _____

Fax# _____

Additional Provider: _____

Specialty _____

Phone# _____

Fax# _____

Would you like for a copy of the report to be mailed to your home address?

☐ Yes ☐ No