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**FORM B : Please complete for 5 consecutive patients referred with a provisional diagnosis of Pure Motor Syndrome, MND or Anterior Horn Cell disease.**

**Please complete for 5 patients for each clinical neurophysiologist within the department.**

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| **Postcode of Centre**  (Please complete) |  |
| **Local EMG Number**  (Please complete) |  |
| **Project code**  (Please leave blank- for office use only) |  |

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| 1. Referral diagnosis? (circle) | MND, Anterior Horn Cell Disease, Pure Motor  Syndrome  Other differential – please state | |
| 2. Speciality of referring clinician?  (circle) | Neurologist  General Physician  Rheumatologist  Other – please state | |
| 3. Time from referral to appointment? (days) |  | |
| 4. Please state the number of muscles tested in each region. (If no muscles tested put 0) | Region | Number of muscles tested |
| Right Cervical |  |
| Left Cervical |  |
| Right Lumbosacral |  |
| Left Lumbosacral |  |
| Right Thoracic |  |
| Left Thoracic |  |
| Right Bulbar |  |
| Left Bulbar |  |
| 5. Please state whether fibrillations/positive sharp waves/ fasciculations were present (Yes/No - please circle) | Right Cervical  Left Cervical  Right Lumbosacral  Left Lumbosacral  Right Thoracic  Left Thoracic  Right Bulbar  Left Bulbar | Yes / No  Yes / No  Yes / No  Yes / No  Yes / No  Yes / No  Yes / No  Yes / No |
| 6. Please state whether chronic neurogenic denervation/reinnervation changes were present (Yes/No- please circle) | Right Cervical  Left Cervical  Right Lumbosacral  Left Lumbosacral  Right Thoracic  Left Thoracic  Right Bulbar  Left Bulbar | Yes / No  Yes / No  Yes / No  Yes / No  Yes / No  Yes / No  Yes / No  Yes / No |
| 7. Studies performed on this patient apart from EMG (Yes/No – please circle) | NCS | Yes / No |
| Proximal motor studies (for assessment of MFMNCB) | Yes / No |
| Repetitive Stimulation | Yes / No |
| MUNE | Yes / No |
| Transcranial Magnetic Stimulation | Yes / No |
| Other – | Yes / No  If yes, please state |
| 8. Was patient anticoagulated? | Yes / No | |
| 9. If Yes: did you perform needle EMG? | Yes / No | |
| 10. Follow up/repeat studies recommended by Clinical Neurophysiologist? | Yes / No  If yes, please give reason(s): | |
| 11. Summary of findings: | | |
| 12. CONCLUSION: | | |