

ORDERING FORM / MEDICAL NECESSITY

STEP 1 COMPLETE PATIENT INFORMATION

Fax: (404) 424-9436

Patient Name:

Pt. Address: City: Zip:

Primary Ins. ID # Ins. Phone #

Secondary Ins. ID # Ins. Phone #

Date of Birth Female Male SS # Pt. Phone #

Symptom Onset Sudden Gradual Duration Accident Yes No DOA

STEP 2 CHECK OFF APPROPRIATE DIAGNOSES

Atty. Name: Atty. Phone #

PATIENT SYMPTOMS		UPPER NERVE CONDUCTION STUDY (ncs, h reflex, sep, dsep)		LOWER NERVE CONDUCTION STUDY (ncs, h reflex, sep, dsep)						
<input type="checkbox"/> Abnormal muscle stretch or superficial reflexes <input type="checkbox"/> Loss of muscle power <input type="checkbox"/> Loss of muscle tone <input type="checkbox"/> Muscle atrophy <input type="checkbox"/> Sensory Loss <input type="checkbox"/> Radiating Pain <input type="checkbox"/> Other: _____ Generalized Neuropathy exists or is suspected: <input type="checkbox"/> No <input type="checkbox"/> Yes (Please indicate below) <input type="checkbox"/> Diabetic <input type="checkbox"/> Alcoholic <input type="checkbox"/> Uremic <input type="checkbox"/> Ischemic <input type="checkbox"/> Immune Other Symptoms: <input type="text"/>		<input type="checkbox"/> Brachial Plexopathy 353.0 <input type="checkbox"/> Carpal Tunnel 354.0 <input type="checkbox"/> Cervical Disc 722.91 <input type="checkbox"/> Cervical Disc W/O Myelopathy 722.0 <input type="checkbox"/> Cervical Myelopathy 721.1 <input type="checkbox"/> Cervical Radiculopathy 723.4 <input type="checkbox"/> Cervicalgia 723.1 <input type="checkbox"/> Median Nerve Neuropathy 354.1 <input type="checkbox"/> Nerve Root Compression 724.9 <input type="checkbox"/> Neuralgia/Neuritis/Radiculitis 729.2 <input type="checkbox"/> Neuropathy of Upper Limb 354.9 <input type="checkbox"/> Pain in Extremities 729.5 <input type="checkbox"/> Pain In Thoracic Spine 724.1 <input type="checkbox"/> Paresthesia 782.0 <input type="checkbox"/> Shoulder Pain 719.41 <input type="checkbox"/> Thoracic Outlet Syndrome 353.0 <input type="checkbox"/> Other _____		<input type="checkbox"/> Foot Drop 736.79 <input type="checkbox"/> Lumbago 724.2 <input type="checkbox"/> Lumbar Myelopathy 721.42 <input type="checkbox"/> Lumbar Radiculopathy 724.4 <input type="checkbox"/> Lumbosacral Disc 722.93 <input type="checkbox"/> Lumbosacral Plexopathy 353.1 <input type="checkbox"/> Neuralgia/Neuritis/Radiculitis 729.2 <input type="checkbox"/> Neuropathy Lower Limb 355.8 <input type="checkbox"/> Pain in Extremities 729.5 <input type="checkbox"/> Pain In Thoracic Spine 724.1 <input type="checkbox"/> Peripheral Neuropathy 356.9 <input type="checkbox"/> Sciatic Neuropathy 355.3 <input type="checkbox"/> Sciatica 724.3 <input type="checkbox"/> Sural Nerve Entrapment 355.79 <input type="checkbox"/> Tarsal Tunnel Syndrome 355.5 <input type="checkbox"/> Thoracic Myelopathy 721.41 <input type="checkbox"/> Other _____						
		MUSCULOSKELETAL ULTRASOUND		EXTREMITY ULTRASOUND 76881						
	neck	back	arm/elbow/shoulder	hand/wrist	foot/ankle	leg/knee/thigh	<input type="checkbox"/> Upper Musculoskeletal Ultrasound <input type="checkbox"/> Lower Musculoskeletal Ultrasound		<input type="checkbox"/> Ankle <input type="checkbox"/> Achilles Bursitis / Tendonitis 726.71 <input type="checkbox"/> Calcaneal Spur 726.73 <input type="checkbox"/> Tibialis Tendonitis 726.72 <input type="checkbox"/> Elbow <input type="checkbox"/> Lateral Epicondylitis 726.32 <input type="checkbox"/> Medical Epicondylitis 726.31 <input type="checkbox"/> Knee <input type="checkbox"/> Tibular/Collateral L Bursitis 726.62 <input type="checkbox"/> Fibular/Collateral L Bursitis 726.63 <input type="checkbox"/> Patellar Tendonitis 726.72 <input type="checkbox"/> Pes Anserinus Tendonitis 726.61 <input type="checkbox"/> Shoulder <input type="checkbox"/> Supraspinatus Syndrome 726.10 <input type="checkbox"/> Wrist <input type="checkbox"/> Bursitis of Hand or Wrist 726.4	
			LT RT	LT RT	LT RT	LT RT	<input type="checkbox"/> Cervical Spondylosis w/o Myelopathy 721.0 <input type="checkbox"/> Cervical Spondylosis w/ Myelopathy 721.1 <input type="checkbox"/> Cervical Pain 723.1 <input type="checkbox"/> Cervical Spinal Stenosis 723.0 <input type="checkbox"/> Thoracic Spondylosis w/o Myelopathy 721.2 <input type="checkbox"/> Thoracic Spondylosis w/ Myelopathy 721.41 <input type="checkbox"/> Thoracic Pain 724.1 <input type="checkbox"/> Thoracic Spinal Stenosis 724.01 <input type="checkbox"/> Lumbar Spondylosis w/o Myelopathy 721.3 <input type="checkbox"/> Lumbar Spondylosis w/ Myelopathy 721.42 <input type="checkbox"/> Lumbar Pain 724.2 <input type="checkbox"/> Lumbar Spinal Stenosis 724.02 <input type="checkbox"/> Sacroillitis Inflammation 720.2			
atrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
coldness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
numb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
spasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
weak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Checking Diagnosis Code Indicates Ordering Test In Highlighted Box Above

Based on the patient's examination, diagnosis, and history, it is my professional opinion that these tests are medically necessary for diagnosis and treatment.

Physician's Name

Physician's Signature

Date

Address:

STEP 3 MUST BE SIGNED BY PHYSICIAN