ORDERING FORM / MEDICAL NECESSITY

STEP 1 COMPLETE PATIENT INFORMATION

Patient Name: _____ **Fax: (561) 717-7122**

Pt. Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth _____ ☐ Female ☐ Male **Pt. Phone #** _____

Primary Ins. _____ **Ins. Phone #** _____

ID # _____ **SS #** _____

Symptom Onset ☐ Sudden ☐ Gradual **Duration** _____ **Accident** ☐ **Yes** ☐ **No** DOA _____

STEP 2 CHECK OFF APPROPRIATE DIAGNOSES Atty. Name: _____ Atty. Phone # _____

UPPER NERVE CONDUCTION STUDY

- ☐ Brachial Plexopathy G54.0
- ☐ Carpal Tunnel G56.0
- ☐ Cervicalgia M54.2
- ☐ Neuropathy of Upper Limb G59.90
- ☐ Pain In Thoracic Spine M54.6
- ☐ Radiculopathy
- ☐ Multiple Sclerosis
- ☐ Disturbance / Skin Sensation
- ☐ Amytrophic L. Sclerosis
- ☐ Compression Nerve Root
- ☐ Lipoprotein Deficiency
- ☐ Neuralgia M79.2
- ☐ Syncope (Fainting)
- ☐ Dizziness
- ☐ Mass Head, Neck
- ☐ Carotid Stenosis
- ☐ Prog.Muscle Atrophy
- ☐ Idiopathic Polyneuropathy
- ☐ Myasthenia Gravis (Acute)
- ☐ Hereditary Mus. Dystrophy
- ☐ Cong. Hereditary Dystrophy
- ☐ Spinal Muscular Atrophy

LOWER NERVE CONDUCTION STUDY

- ☐ Lumbago M54.5
- ☐ Lumbosacral Disc M51.37
- ☐ Neuropathy Lower Limb G57.50
- ☐ Peripheral Neuropathy G60.00
- ☐ Tarsal Tunnel Syndrome G57.50
- ☐ Sciatica M54.30
- ☐ Primary L Sclerosis
- ☐ Spinla Myeo./ Compression
- ☐ Myasthenia Gravis
- ☐ Rule Out_____

MUSCULOSKELETAL / TRANSCRANIAL DOPPLER / CAROTID

- ☐ Cervical Spondylosis
- ☐ Cervical Pain
- ☐ Cervical Spinal Stenosis
- ☐ Thoracic Spondylosis
- ☐ Thoracic Pain
- ☐ Thoracic Spinal Stenosis
- ☐ Lumbar Spondylosis
- ☐ Arterial Embolism Upper Ext.
- ☐ Arterial Embolism Lower Ext.
- ☐ Peripheral Vascular Disease
- ☐ Lumbar Pain
- ☐ Lumbar Spinal Stenosis
- ☐ Dizziness
- ☐ Carotid Stenosis
- ☐ Headaches or Migraines
- ☐ Syncope (Fainting)
- ☐ Pain in Limb
- ☐ Artherosclerosis
- ☐ Injury Axilla Vessel
- ☐ Apnea
- ☐ Mass Head, Neck
- ☐ Cerebral Artery Inclusion
- ☐ Vertebral Artery Syndrome
- ☐ T.I.A.
- ☐ Introvert Joint Displacement M51.2
- ☐ Atrial Fibrillation
- ☐ Swelling of Limb
- ☐ Unspec.Chest Pain
- ☐ Venous Insufficiency (Peripheral)
- ☐ Rule Out:_____

SYMPTOMS

- ☐ Muscle atrophy
- ☐ Radiating Pain
- ☐ Abnormal muscle stretch
- ☐ Sensory Loss
- ☐ Loss of muscle power
- ☐ Loss of muscle tone
- ☐ Diabetic ☐ Alcoholic ☐ Uremic ☐ Ischemic
- ☐ Immune
- ☐ Other: _____

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 _____

STEP 3 MUST BE SIGNED BY PHYSICIAN

Address:

Phone (877) 397-3130 | Fax (561) 717-7122