ORDERING FORM / MEDICAL NECESSITY

STEP 1 COMPLETE PATIENT INFORMATION

Fax: (561) 717-7122

Patient Name:

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 + TRANSCRANIAL

- ☐ Back Pain
- ☐ Carpal Tunnel
- ☐ Cervicalgia
- ☐ Neuropathy of Upper Limb
- ☐ Pain In Thoracic Spine
- ☐ Neuralgia
- ☐ Carpal Tunnel Syndrome
- ☐ Diabetic Neuropathy
- ☐ Carotid Stenosis
- ☐ Syncope (Fainting)
- ☐ Rule Out________________________

LOWER NERVE CONDUCTION STUDY +TRANSCRANIAL

- ☐ Lumbago
- ☐ Lumbosacral Disc
- ☐ Neuropathy Lower Limb
- ☐ Peripheral Neuropathy
- ☐ Neuralgia
- ☐ Tarsal Tunnel Syndrome
- ☐ Sciatica
- ☐ Syncope (Fainting)
- ☐ Peripheral Nerve Injury
- ☐ Mass Head, Neck
- ☐ Carotid Stenosis
- ☐ Rule Out________________________

CAROTID/ARTERIAL ULTRASOUND

- ☐ Carotid Stenosis
- ☐ Dizziness
- ☐ Mass Head, Neck
- ☐ Syncope (fainting)
- ☐ T.I.A.
- ☐ Arterial Embolism Upper Ext.
- ☐ Arterial Embolism Lower Ext.
- ☐ Atherosclerosis
- ☐ Injury Axillary Vessel
- ☐ Pain in Limb
- ☐ Peripheral Vascular Disease

CAROTID/VENOUS ULTRASOUND

- ☐ Carotid Stenosis
- ☐ Dizziness
- ☐ Mass Head, Neck
- ☐ Syncope (fainting)
- ☐ Apnea
- ☐ Atrial Fibrillation
- ☐ Swelling of Limb
- ☐ Pain in Limb
- ☐ Unspec. Chest Pain
- ☐ Venous Insufficiency (Peripheral)

MUSCULOSKELETAL ULTRASOUND

- ☐ Cervical Spondylosis
- ☐ Cervical Pain
- ☐ Cervical Spinal Stenosis
- ☐ Thoracic Spondylosis
- ☐ Thoracic Pain
- ☐ Thoracic Spinal Stenosis
- ☐ Lumbar Spondylosis
- ☐ Lumbar Pain
- ☐ Lumbar Spinal Stenosis
- ☐ Rule Out________________________

TRANSCRANIAL DOPPLER / CAROTID

- ☐ Lack of Coordination
- ☐ Carotid Stenosis
- ☐ Mass Head, Neck
- ☐ Syncope (Fainting)
- ☐ Vertebnobasilar Artery Syndrome
- ☐ Cerebral Artery Inclusion
- ☐ Vertebral Artery Syndrome
- ☐ T.I.A.
- ☐ Symptoms of the Musculoskeletal System
- ☐ Rule Out:________________________

	neck	back	arm/elbow/shoulder		hand/wrist		foot/ankle		leg/knee/thigh	
			LT	RT	LT	RT	LT	RT	LT	RT
atrophy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
coldness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
numb	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
spasm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
tingling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
weak	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SYMPTOMS

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

Other Symptoms:

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