

# NERVE CONDUCTION/ ELECTROMYOGRAPHY

Scheduling: (972) 506-7800 Fax: (972) 831-8015

Order Form

Please provide an enlarged copy of Patient's Demographic/Insurance card information or complete entire form.

**Required fields**

**Patient:** \_\_\_\_\_  **SSN:** \_\_\_\_\_  **D.O.B.:** \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City: \_\_\_\_\_ TX, Zip Code: \_\_\_\_\_ Work/Mobile Phone: \_\_\_\_\_  
Sex:  M  F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Primary Insurance Company: \_\_\_\_\_  HMO  PPO  POS  EPO

Referring Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
City: \_\_\_\_\_ TX, Zip Code: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**I AUTHORIZE THE FOLLOWING STUDY TO BE PERFORMED (CHECK APPROPRIATE TESTS):**

- |  |                   |  |
|--|-------------------|--|
| <input type="checkbox"/> <b>Bilateral Upper NCV</b>          | (No EMG Required) | NCV of Upper Extremities (Carpal Tunnel Syndrome)                  |
| <input type="checkbox"/> <b>Bilateral Lower NCV*</b>         |                   | NCV of Lower Extremities (One Upper as Control/ Diabetic Protocol) |
| <input type="checkbox"/> <b>Upper NCV with EMG</b>           |                   | NCV and EMG of Upper Extremities (Includes Muscle Test)            |
| <input type="checkbox"/> <b>Lower NCV with EMG</b>           |                   | NCV and EMG of Lower Extremities (Includes Muscle Test)            |
| <input type="checkbox"/> <b>Pain Management Consultation</b> |                   | Evaluation and Management of Complaints of Pain.                   |

Commercial insurance plans may require EMG study concurrently or within the past year

**THIS STUDY IS MEDICALLY NECESSARY BECAUSE THE PATIENT IS EXHIBITING THE FOLLOWING SYMPTOMS:**

- |  |  |  |                                |
|--|--|--|--------------------------------|
| <input type="checkbox"/> <b>354.0</b>        | <b>Unilateral / Bilateral Carpal Tunnel Syndrome</b>             | <input type="checkbox"/> <b>724.1</b>  | <b>Pain in Thoracic Spine</b>  |
| <input type="checkbox"/> <b>782.0</b>        | <b>Disturbance of Skin Sensation (Paresthesia)</b>               | <input type="checkbox"/> <b>729.5</b>  | <b>Pain In Limb</b>            |
| <input type="checkbox"/> <b>354.2</b>        | <b>Lesion of Ulnar Nerve</b>                                     | <input type="checkbox"/> <b>354.1</b>  | <b>Median Nerve Neuritis</b>   |
| <input type="checkbox"/> <b>356.9</b>        | <b>Unspecified Idiopathic Peripheral Neuropathy</b>              | <input type="checkbox"/> <b>356.9</b>  | <b>Neuropathy, Unspecified</b> |
| <input type="checkbox"/> <b>356.4</b>        | <b>Idiopathic Progressive Polyneuropathy</b>                     | <input type="checkbox"/> <b>724.3</b>  | <b>Sciatica</b>                |
| <input type="checkbox"/> <b>724.4</b>        | <b>Thoracic/Lumbosacral Neuritis/Radiculitis, Unspecified</b>    | <input type="checkbox"/> <b>781.2</b>  | <b>Abnormality of Gait</b>     |
| <input type="checkbox"/> <b>357.2/250.6*</b> | <b>Diabetes with Neurological Manifestations/ Polyneuropathy</b> | <input type="checkbox"/> <b>Other:</b> |                                |

\* Must include Diabetes information below

\*Is Patient Diabetic:  Yes  No Type: \_\_\_\_\_ How Long: \_\_\_\_\_  
Diabetes Controlled:  Yes  No  
Currently on Anticoagulant:  Yes  No Waive EMG:  Yes  No

Special Instructions: \_\_\_\_\_

**Date of Symptom Onset:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_  **Date:** \_\_\_\_\_

**Physician Name:** \_\_\_\_\_  **Completed By:** \_\_\_\_\_