

CERTIFICATE OF MEDICAL NECESSITY

Name of Patient: _____ Age: _____

Date of Last Examination _____

Symptom Onset Sudden Gradual Duration _____

Accident/Injury Yes No Prior NCV/EMG/US Tests? Yes No

COMPLETE EXTREMITY SYMPTOMS SECTION								
	Arm/shoulder/elbow		Hand/Wrist		Thigh/knee/leg		Foot/Ankle	
	LT	RT	LT	RT	LT	RT	LT	RT
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"/>
Numbness	<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"/>
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"/>
Weakness	<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"/>
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"/>
<input type="checkbox"/> Pain in Limb 729.5								

Physician's Name _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Date: ____ / ____ / ____

Signature: _____

COMPLETE FOR SPINAL/EXTREMITY ULTRASOUND	
Neck Pain	<input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Boring <input type="checkbox"/> Intermittent <input type="checkbox"/> Constant <input type="checkbox"/> Localized to Neck <input type="checkbox"/> 721.0 Cervical spondylosis without myelopathy <input type="checkbox"/> 721.1 Cervical spondylosis with myelopathy <input type="checkbox"/> 723.1 Cervical Pain <input type="checkbox"/> 723.0 Cervical Spinal Stenosis
Back Pain	<input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Boring <input type="checkbox"/> Intermittent <input type="checkbox"/> Constant <input type="checkbox"/> Localized to Back <input type="checkbox"/> 721.2 Thoracic spondylosis without myelopathy <input type="checkbox"/> 721.41 Thoracic spondylosis with myelopathy <input type="checkbox"/> 724.1 Thoracic Pain <input type="checkbox"/> 724.01 Thoracic spinal stenosis <input type="checkbox"/> 721.3 Lumbar spondylosis without myelopathy <input type="checkbox"/> 721.42 Lumbar spondylosis with myelopathy <input type="checkbox"/> 724.2 Lumbar Pain <input type="checkbox"/> 724.02 Lumbar spinal stenosis
Extremities	<input type="checkbox"/> 720.2 Sacroillitis inflammation of S.I. Joint (S.I. Joint) <input type="checkbox"/> 726.10 Supraspinatus syndrome (shoulder) <input type="checkbox"/> 726.31 Medial epicondylitis (Elbow) <input type="checkbox"/> 726.32 Lateral epicondylitis (Elbow) <input type="checkbox"/> 726.4 Bursitis of hand or wrist (Wrist) <input type="checkbox"/> 354.0 Carpal tunnel/med. nerve <input type="checkbox"/> 726.5 Bursitis of hip (Hip) <input type="checkbox"/> 726.61 Pes Anserinus tendonitis / bursitis (Knee) <input type="checkbox"/> 726.62 Tibular / Collateral L bursitis (Knee) <input type="checkbox"/> 726.63 Fibular/Collateral L bursitis (Knee) <input type="checkbox"/> 726.64 Patellar tendonitis (Knee) <input type="checkbox"/> 726.71 Achilles bursitis / tendonitis (Ankle) <input type="checkbox"/> 726.72 Tibialis tendonitis (Ankle) <input type="checkbox"/> 726.73 Calcaneal spur (Ankle)

COMPLETE FOR NERVE CONDUCTION STUDIES	
Each section must be checked	
<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 (<i>Indicate disease below</i>) <input type="checkbox"/> Diabetic <input type="checkbox"/> Alcoholic <input type="checkbox"/> Uremic <input type="checkbox"/> Ischemic <input type="checkbox"/> Immune <input type="checkbox"/> _____	
Present Findings Indicate The Following Diagnosis(es)	
<input type="checkbox"/> Carpal tunnel/med. nerve 354.0 <input type="checkbox"/> Neuropathy, median nerve 354.1 <input type="checkbox"/> Neuropathy, ulnar nerve 354.2 <input type="checkbox"/> Neuropathy, radial nerve 354.3 <input type="checkbox"/> Neuropathy, sciatic 355.0 <input type="checkbox"/> Neuropathy, peroneal 355.3 <input type="checkbox"/> Neuropathy, tibial 355.4 <input type="checkbox"/> Tarsal tunnel syndrome 355.5 <input type="checkbox"/> Entrapment, sural nerve 355.7 <input type="checkbox"/> Neuropathy, upper limb 354.9 <input type="checkbox"/> Neuropathy, lower limb 355.8 <input type="checkbox"/> Neuropathy, peripheral 356.9 <input type="checkbox"/> _____ (_____)	<input type="checkbox"/> Plexopathy, brachial 353.0 <input type="checkbox"/> Plexopathy, lumbosacral 353.1 <input type="checkbox"/> Thoracic outlet syndrome 353.0 <input type="checkbox"/> Mononeuritis multiplex 354.5 <input type="checkbox"/> Neuroma, plantar 355.6 <input type="checkbox"/> Cervicobrachial syndrome 723.3 <input type="checkbox"/> Radiculopathy, cervical 723.4 <input type="checkbox"/> Wrist drop 736.05 <input type="checkbox"/> Foot drop 736.79 <input type="checkbox"/> Radiculopathy, lumbar 724.4 <input type="checkbox"/> Compression, nerve root 724.9 <input type="checkbox"/> Diabetes (specify type) 250.6__ <input type="checkbox"/> Disturbance/skin sensation 782.0
Diagnostic procedures include Nerve Conduction Studies, Somatosensory Evoked Potentials, & Electromyography* <input type="checkbox"/> Upper Series <input type="checkbox"/> Lower Series <input type="checkbox"/> Full Series Diagnostic procedures include Musculoskeletal Ultrasound <input type="checkbox"/> Upper Series <input type="checkbox"/> Lower Series <input type="checkbox"/> Full Series Based on the patient's examination, history and diagnoses, it is my professional opinion that these tests are medically necessary for diagnosis and treatment.	
*Where available	