REAL VIEW DIAGNOSTICS

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Southwest Sport & Spine Center

REFERRAL FOR DIAGNOSTIC TESTING

PATIENT NAME: _____ **DATE:** _____

The above patient presents with the following conditions/symptoms. This referral establishes Medical Necessity for patient to undergo the specified diagnostic testing to assist in accurate diagnosis and effective patient management.

NCS/EMG

	Numbness in fingers
	Numbness in toes
	Burning Sensation
	Back Pain with Radiculopathy
	Neck Pain with Radiculopathy
	Muscle Weakness
	Myopathy
	Diabetic Neuropathy
	Hypothyroidism Neuropathy
	Other:

MSKUS

	Shoulder Rotator Cuff Tear
	Shoulder Effusion/Tendinosis
	Elbow Med. Epicondyle Tendinosis
	Elbow Lat. Epicondyle Tendinosis
	Wrist/Hand Effusion/Tendinosis
	Wrist/Hand Muscle/Ligament Tear
	Knee Effusion/Tendinosis
	Knee Derangement
	Ankle/Foot Effusion/Tendinosis
	Ankle/Foot Derangement
	Arthropathies
	Neuromas & Ganglia
	Other:

PROVIDER'S SIGNATURE: _____

PROVIDER'S PRINTED NAME: _____

HandsOn DIAGNOSTICS
Healing Hands Guided by Technology
APPROVED DIAGNOSTICS CENTER