Referral for Diagnostic Testing

INSIGHT Diagnostics Group

14017 N. Eastern Avenue Edmond, OK 73013, United States

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

_____ Tingling

_____ 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. EpicondyleTendin.

_____ Elbow Lat. Epicondyle Tendin.

_____ Wrist/Hand Effusion / Tendin.

_____ Wrist/Hand Muscle / Ligmnt Tear

_____ Knee Effusion / Tendinosis

_____ Knee Derangement

_____ Ankle/Foot Effusion / Tendinos

_____ Ankle/Foot Derangement

_____ Arthropathies

_____ Neuromas & Ganglia

Other: _____

_____ Doctor's Name

_____ Doctor's Signature