ELECTRODIAGNOSTIC EXAMINATION (V-s NCT) REFERRAL FORM

The following information is required for proper processing of this test. Please check off all areas and diagnoses that apply to the patient and feel free to provide additional information that does not appeared on this form.

Patient's Name:

Date of Service: D/O/A:

Referring Doctor:

☐ Cervical/ Thoracic nerves evaluation

☐ Lumbarsacral nerves evaluation

REASON FOR ORDERING TEST

SUBJECTIVE FINDINGS

☐ Neck pain and stiffness

☐ Lower back pain and stiffness

☐ Upper back pain and stiffness

☐ Middle back pain and stiffness

UPPER EXTREMITIES

(Please check off clinical/working diagnosis and laterality of suspected lesion)

L	R	B	
☐	☐	☐	839.08 Multiple Subluxation
☐	☐	☐	723.1 Cervicalgia
☐	☐	☐	723.2 Cervicocranial Syndrome
☐	☐	☐	723.3 Cervicobrachial Syndrome
☐	☐	☐	723.4 Cervical Rediculitis
☐	☐	☐	729.1 Myalgia/Myositis
☐	☐	☐	728.85 Muscls Spasm
☐	☐	☐	782.0 Numbness/Tingling

LOWER EXTREMITIES

L	R	B	
☐	☐	☐	839.2 Lumbar Sublaxations
☐	☐	☐	839.42 Sacroilliac Subluxations
☐	☐	☐	724.2 Lumbosacral Radiculitis
☐	☐	☐	724.8 Lumbago
☐	☐	☐	723.4 Lumbar Facet Syndrome
☐	☐	☐	729.1 Myalgia/Myositis
☐	☐	☐	728.85 Muscls Spasm
☐	☐	☐	782.0 Numbness/Tingling

Other:

ADDITIONAL CLINICAL INFORMATION

☐ Rule in/out spinal nerve root lesion (Spinal Level,Laterality,Severity)

☐ Rule in/out suspected preipheral nerve entrapment syndrome

☐ Rule in/out referred pain syndrome (Myofacial or sclerotogenous origin vs. nerve root lesion)

DOCTOR'S COMMENTS:

Doctor's Signature

Name(Nombre): Age(Edad):

D.O.A (FECHA DE ACCIDENTE):

Were you the (Usted era): ☐ Driver(Chofer) ☐ Passenger(Pasajero) ☐ Pedestrian(Peaton) ☐ Bicyclist

Please mark an "X" where you feel pain on the diagram below, and/or any other symptoms such as:
pain, tingling, feeling or numbness, since you accident.

(Por favor de markar una "X" donde le duele en el sigiente diagrama, incluyendo sintomas de dolores, calambre, o adormecimiento.)

PATIENT'S SIGNATURE (FIRMA)

DATE (FECHA)