Referral for Diagnostic Testing
Diagnostic Solutions LLC

1113-A Lincoln Park Rd. Springfield, KY 40069

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.

EMG/NCV

_____ 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