ORDERING FORM / MEDICAL NECESSITY - PODIATRY

AMERICANIMAGING

Fax: (404) 424-9436

STEP 1 COMPLETE PATIENT INFORMATION

Patient Name:

Pt. Address:

Primary Ins. **ID #** **Ins. Phone #**

Secondary Ins. **ID #** **Ins. Phone #**

Date of Birth ☐ Female ☐ Male **SS #** **Pt. Phone #**

STEP 2 CHECK OFF APPROPRIATE DIAGNOSES

LOWER NERVE CONDUCTION STUDY

- ☐ Diabetes - Specify Type 250.60
- ☐ Entrapment Sural 355.0
- ☐ Muscle Weakness 728.87
- ☐ Neuropathy Plantar Nerve 355.6
- ☐ Neuropathy Lower Limb 355.68
- ☐ Orofacial Dyskinesia 333.82
- ☐ Other Musculoskeletal Symptoms 728.89
- ☐ Pain in Limb 729.5
- ☐ Peroneal Entrapment 355.3
- ☐ Spinal Cord Myelopathy 336.9
- ☐ Tarsal Tunnel 355.5
- ☐ Tibial Neuropathy 355.4
- ☐ Uspec. Disorder of muscle/ligament/728.9
- ☐ Peripheral Neuropathy 356.9

LOWER EXTREMITY ARTERIAL

- ☐ Atherosclerosis of Aorta 440.0
- ☐ Atherosclerosis w/ Pain Walking 440.21
- ☐ Atherosclerosis w/ Rest Pain 440.22
- ☐ Atherosclerosis w/ Ulcers 440.23
- ☐ Arterial Embolism & Thrombosis 444.21
- ☐ Chronic Ulcer of skin 707.10
- ☐ Due to Cardiac Pacemaker 996.01
- ☐ Gangrene 785.4
- ☐ Hematoma Complicating a Procedure 998.12
- ☐ Injury to Blood Vessel Lower Ext. 904.0
- ☐ Injury to Vessel 903.00
- ☐ Other Peripheral Vascular Disease 443.89
- ☐ Palmar Artery 903.4
- ☐ Peripheral Vascular Disease, Unspec. 443.9
- ☐ Radial Blood Vessels 903.2
- ☐ Ulcer of Ankle 707.13
- ☐ Ulcer of Heel and Mid-Foot 707.14
- ☐ Ulcer of Other Part of Foot 707.15
- ☐ Ulnar Blood Vessels 903.3

LOWER EXTREMITY VENOUS

- ☐ Chronic Venous Hypertension w/ Ulcer 459.31
- ☐ Chronic Venous Hypertension w/ Other 459.39
- ☐ Edema 782.3
- ☐ Gangrene 785.4
- ☐ Localized Superficial Swelling 782.2
- ☐ Pain in Limb 729.5
- ☐ Phlebitis & Thrombophlebitis 451.0
- ☐ Varicose Veins of Lower Extremities w/ Ulcer 454.0

Other Procedure:

Other Diagnosis:

Checking Diagnosis Code Indicates Ordering Test In Highlighted Box Above

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Based on the patient's examination, diagnosis, and history, it is my professional opinion that these tests are medically necessary for diagnosis and treatment.

Physician's Name

Physician's Signature

Date

STEP 3 MUST BE SIGNED BY PHYSICIAN

Address (stamp for convenience)**:**

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