



Hands-On Diagnostics of Alaska

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www.hodsak.com

Referral for Diagnostic Testing

Patient Name: _____ DOB: _____

Patient Phone #: _____ Date of Referral: _____

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

EMG/NCS

___ Numbness in fingers

___ Numbness in toes

___ Tingling

___ Burning Sensation

___ Back Pain

___ Neck Pain

___ Radiating Pain

___ Muscle Weakness

___ Diabetes Neuropathy

___ Hypothyroidism Neuropathy

EVOKED POTENTIALS

___ Numbness/Tingling in bilateral hands/feet

___ Spinal Stenosis

___ Muscle Weakness

___ Diabetes Neuropathy

___ Paresthesia

___ Visual Disturbance

___ Auditory Disturbance

___ Dizziness

___ Balance/Gait Abnormalities

___ Vertigo

MUSCULOSKELETAL ULTRASOUND

___ Shoulder Pain

___ Elbow Pain

___ Wrist/hand Pain

___ Knee Pain

___ Ankle/Foot Pain

___ Arthropathies

___ Tendinopathies

___ Joint Effusion

___ Neuromas & Ganglia

___ Nerve Entrapments

Comments: _____

Physician Name: _____ Office #: _____

Physician Signature: _____ Date: _____