EMG/NCS Referral Form

GAMMA THERAPEUTIC CENTER
Center for Neurological Disorders

10750 W. Howard Ave
Greenfield, WI 53228
Phone: (414) 460-3195
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Patient Information	
Patient Name:	Patient DOB:

Request Testing of					
☐ RUE	☐ LUE	☐ RLE	☐ LLE	☐ BUE	☐ BLE

Evaluate for	
☐ Carpal Tunnel Syndrome	☐ Cervical lumbosacral
☐ Tarsal Tunnel Syndrome	☐ Brachial Plexopathy
☐ Ulnar Neuropathy	☐ Suprascapular Injury
☐ Other Focal Neuropathy	☐ Other:
☐ Peripheral Neuropathy	

Sourporting Documentation	
☐ Patient demographics	☐ Clinical/Progress notes
☐ Copy of patient insurance card(s) – front & back	☐ Copy of Worker's Compensation Paperwork

Worker's Compensation Only	
Claim Number:	Date of Injury:

Notes (Additional Info)

Prescriber Information		
Prescriber Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:		Date: (Order is valid for 90 Days)

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

Notify patient we will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.