



Empire Diagnostic Solutions, Inc.

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91-31 Queens Blvd, Suite C, Elmhurst, NY 11373
(Please take the elevator to the lower level)

PLEASE FAX ALL REQUESTS TO: 877-554-9107

REFERRING PHYSICIAN:	DATE OF SERVICE:
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LAST NAME:	FIRST NAME:
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PATIENT'S ADDRESS:

PRIMARY INSURANCE:

ID NUMBER:

SECONDARY INSURANCE:

ID NUMBER:

DATE OF BIRTH:	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
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PATIENT'S PHONE NUMBER:	S.S.#:
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Lower Extremity Arterial with PVR/ABI/TBI Measurements	Lower Extremity Venous	Nerve Conduction Studies
<input type="checkbox"/> BILATERAL 93923 & 93925 <input type="checkbox"/> UNILATERAL 93926	<input type="checkbox"/> BILATERAL 93970 <input type="checkbox"/> UNILATERAL 93971	<input type="checkbox"/> LOWER
<input type="checkbox"/> Atherosclerosis of aorta 440.0	<input type="checkbox"/> Chronic venous hypertension 459.31	<input type="checkbox"/> Diabetes w/neurological manifestations 250.60
<input type="checkbox"/> Atherosclerosis w/pain walking 440.21	<input type="checkbox"/> Chronic venous hypertension w/ulcer 459.39	<input type="checkbox"/> Disturbance of skin sensation 782.0
<input type="checkbox"/> Atherosclerosis w/rest pain 440.22	<input type="checkbox"/> DVT 453.40	<input type="checkbox"/> Entrapment Sural 355.0
<input type="checkbox"/> Atherosclerosis w/ulcers 440.23	<input type="checkbox"/> Edema 782.3	<input type="checkbox"/> Muscle weakness 728.87
<input type="checkbox"/> Atherosclerosis w/gangrene 440.24	<input type="checkbox"/> Gangrene 785.4	<input type="checkbox"/> Neuropathy plantar nerve 355.6
<input type="checkbox"/> Atherosclerosis of bypass graft 440.30-440.32	<input type="checkbox"/> Localized superficial swelling, mass or lump 782.2	<input type="checkbox"/> Orofacial Dyskinesia 333.82
<input type="checkbox"/> Arterial embolism & thrombosis of arteries of extremities 444.21-444.22	<input type="checkbox"/> Pain in limb 729.5	<input type="checkbox"/> Pain in limb 729.5
<input type="checkbox"/> Chronic ulcer of skin of lower limb unspecified 707.10	<input type="checkbox"/> Phlebitis & thrombophlebitis 451.0	<input type="checkbox"/> Peroneal entrapment 355.3
<input type="checkbox"/> Diabetes w/peripheral circulatory disorder 250.70-250.73	<input type="checkbox"/> Postphlebotic syndrome 459.10	<input type="checkbox"/> Spinal cord myelopathy 336.9
<input type="checkbox"/> Gangrene 785.4	<input type="checkbox"/> Postphlebotic syndrome w/ulcer 459.11	<input type="checkbox"/> Tarsal tunnel 355.5
<input type="checkbox"/> Hematoma complicating a procedure 998.12	<input type="checkbox"/> Postphlebotic syndrome w/ inflammation 459.12	<input type="checkbox"/> Tibial neuropathy 355.4
<input type="checkbox"/> Hemorrhage complicating a procedure 998.11	<input type="checkbox"/> Postphlebotic syndrome w/other complications 459.19	<input type="checkbox"/> Unspecified disorder of muscle/ligament/fascia 728.9
<input type="checkbox"/> Injury to blood vessels of lower extremity & unspecified sites 904.0-904.8	<input type="checkbox"/> Pulmonary embolism & infraction 415.11	<input type="checkbox"/> Other
<input type="checkbox"/> Injury to vessel, arm 903.00-903.9	<input type="checkbox"/> Superficial thrombophlebitis complicating pregnancy 671.20	
<input type="checkbox"/> Other peripheral vascular disease 443.89	<input type="checkbox"/> Swelling of limb 729.81	
<input type="checkbox"/> Palmar artery 903.4	<input type="checkbox"/> Varicose veins of lower extremities w/ulcer 454.0	
<input type="checkbox"/> Peripheral vascular disease, unspecified 443.9	<input type="checkbox"/> Varicose veins of lower extremities w/other complications 454.8	
<input type="checkbox"/> Radial blood vessels 903.2	<input type="checkbox"/> Other	
<input type="checkbox"/> Ulcer of ankle 707.13		
<input type="checkbox"/> Ulcer of heel and mid-foot 707.14		
<input type="checkbox"/> Ulcer of other part of foot 707.15		
<input type="checkbox"/> Ulnar blood vessels 903.3		

SPECIFIC CLINICAL HISTORY IS NECESSARY FOR BETTER DIAGNOSTIC EVALUATION

HISTORY: _____

I certify that the above ordered tests are medically necessary for this patient.

PHYSICIAN'S SIGNATURE: _____

