NEBRASKA ORTHOPAEDIC AND SPORTS MEDICINE, PC

Nerve Conduction Studies Order Form

Joseph P. Mulka, M.D., Ph.D., Diplomate, ABPMR

Appointment Scheduling

Please complete the following information or ATTACH PATIENT'S FACE SHEET and include the patient's Summary of Care via fax to **(402) 488-3324**.

Patient Legal Name: _____ Patient DOB: _____

Patient Primary Contact Number: _____ Patient Secondary Contact Number: _____

Insurance Carrier: _____ Insurance Number: _____

Work Comp? ☐ Yes ☐ No

Please indicate if: ☐ Patient will call to schedule appointment ☐ Our office to call Patient to schedule appointment

Clinical Question/Reason for Nerve Conduction Study

☐ Carpal Tunnel Syndrome ☐ Peripheral Neuropathy ☐ Cervical Radiculopathy ☐ Lumbar Radiculopathy

☐ Cubital Tunnel Syndrome ☐ Other _____

Patient's Symptoms

☐ Pain ☐ Tingling ☐ Numbness ☐ Weakness

Extremity(s) Involved

☐ Right Upper Extremity ☐ Left Upper Extremity ☐ Right Lower Extremity ☐ Left Lower Extremity

(may select multiple)

Follow-up Requested

☐ Referral to appropriate Specialist as indicated by test results

☐ Results only sent back to referring physician

Special Instructions:

Ordering Physician: _____

Office Contact person: _____ Office phone: _____ ext._____

Questions? Call Lisa R., RN at (402) 484-4061 ***Reminder*: Fax this form to (402) 488-3324**