LETTER OF MEDICAL NECESSITY
DOCTOR'S VASCULAR TEST ORDER FORM
(Please provide as much detail as possible)

Patient: ___________________ Age __ Test Date: __/__/__ Referring Doctor ______________________

☐ Upper Vascular Study  ☐ Lower Vascular Study

**ARTERIAL STUDIES**
- Duplex Scan of Lower Extremity Arteries (Bilateral)
- Non-Invasive Physiologic Studies of Extremity Arteries

**VENOUS STUDIES**
- Duplex Scan of Lower Extremity Veins (Bilateral)
- Non-Invasive Physiologic Studies of Extremity Veins

**PATIENT ENTERED OFFICE WITH COMPLAINTS OF:**

- Neck Pain
- Cold Hands / Feet
- Low Back Pain
- Leg / Foot Pain
- Numbness In:
- Pins and Needles
- Nausea
- Neck Pain Radiating to Upper extremities
- Weakness in Hands
- Hand Pain:
- Leg / Foot Cramps
- Weakness:
- Arms
- Legs
- Hands
- Feet
- Other:

**PRELIMINARY EXAMINATION REVEALED:**

- Sensory loss of extremities
- Muscle weakness of extremities
- Reflex asymmetry at
- Muscle Spasm at
- Decreased range of motion of the:
- Cervical spine
- Lumbar spine
- Decreased range of motion at
- Muscle Atrophy of:
- Left
- Right
- Upper extremity
- Lower extremity
- Hand / Numbness & Tingling
  - Left
  - Right
  - Allen’s Test
  - Buerger’s Test
- Cervical Compression
- Pos
- Negative
- Wright’s Test
- Pos
- Negative
- Cervical Distraction
- Pos
- Negative
- KEMPS
- SLR
- Reverse Bakody
- Romberg’s

**WORKING DIAGNOSIS:**

- Screening V81.0
- Aneurysm of Artery of Upper Extremities
- Arteriosclerosis of Extremities
- Arteriosclerosis of Lower Extremities
- Gangrene
- Injury to Blood Vessels
- Peripheral Vascular Disease
- PVD, Claudication (Cramping)
- Rest Pain of Lower Extremity
- Other:

**ARTERIAL STUDIES**

- Screening V81.0
- Anomaly of Peripheral Vascular System
- Congenital Vascular Anomaly
- Edema
- Embolism of Vein
- Gangrene
- Hemoptyisis
- Injury of Blood Vessels
- Leg Pain
- Other:

**VENOUS STUDIES**

Based on this patient's history, examination and differential diagnosis, I have requested these vascular studies. I hereby certify that the tests ordered are medically necessary for appropriate diagnosis and treatment.

Doctor’s Printed Name: ___________________ Signature: ___________________

Form E – Rev. 3.0