National Scoliosis CENTER™
nationalscoliosiscenter.com

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Prescription/Referral Form

Patient Information

Name _____

Date of Birth _____

DX _____

Bracing

☐ *Custom TLSO/Rigo Cheneau Brace*

☐ *Other* _____

Radiology

2 view X-Ray service (AP and lateral) or those related to scoliosis only.

No chest or fracture X-rays.

☐ 72081 Radiologic Exam, Spine, Entire, 1 View

☐ 72082 Radiologic Exam, Spine, Entire, 2 or 3 Views

☐ 77073 Bone Length Studies

☐ 77072 Bone Age Study, Hand 1 View

☐ Radiology Exam Other. Please specify: _____

_____

The EOS provides ultra-low dose radiation. The report from the radiologist will be faxed to the referring physician. Images will be shared electronically (if available) and/or provided to the patient on a CD.

Referring Physician

I CERTIFY THAT I HAVE PRESCRIBED THIS ITEM AND THAT IT IS MEDICALLY NECESSARY FOR THE CARE OF MY PATIENT.

Physician's Name (printed) _____

Physician's Signature _____ Date _____

Physician's Phone # _____ Fax # _____

NPI # _____