Integrated Practice Resources, LLC
Scheduling Form
Fax to 1-888-395-3941

Testing Date M T W TH F S ___/___/___

Physician Name _____

Office Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact: _____

IMPORTANT

1 hour for a single test (upper or lower profile)
2 hours for a double test (upper and lower profile on the same patient)

Fax this sheet, Certifications of Medical Necessity, Patient Referral & Intake forms and the patients' insurance cards to 1-888-395-3941. If you have any questions, please call 1-888-395-4007

Fax to 1-888-395-3941

TIME	PATIENT NAME	TESTING PROFILE								
		NCV			Ultrasound			Extremity		
_____ Am	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		
_____ Am	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		
_____ Am	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		
_____ Am	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		
_____ Am	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		
_____ Am	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		
_____ Am	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		
_____ Please allow time for lunch break										
_____ Pm	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		
_____ Pm	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		
_____ Pm	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		
_____ Pm	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		
_____ Pm	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		
_____ Pm	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		
_____ Pm	_____	☐ Upper	☐ Lower	☐ Full	☐ Upper	☐ Lower	☐ Full	_____		