



# CA|DMX – ORDER FORM

Scheduling: 855-369-7291 | FAX: 855-369-7291

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Guardian Name (If Applicable): \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Male  Female  | Pregnant: Yes  No

## ORDERING PHYSICIAN INFORMATION

Referring Provider: \_\_\_\_\_ Email: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

NPI Number: \_\_\_\_\_ CA License #: \_\_\_\_\_

Address: \_\_\_\_\_

## DIGITAL MOTION X-RAY (DMX) EVALUATION FOR: (choose all that apply)

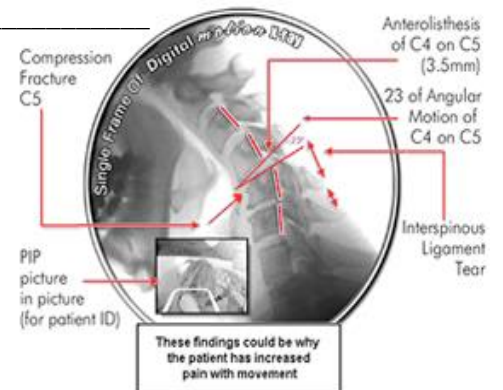
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Cervical Spine   | <input type="checkbox"/> TMJ           | <input type="checkbox"/> Wrist (RT/LT) |
| <input type="checkbox"/> Shoulder (RT/LT) | <input type="checkbox"/> Elbow (RT/LT) | <input type="checkbox"/> Ankle (RT/LT) |
| <input type="checkbox"/> Hip (RT/LT)      | <input type="checkbox"/> Knee (RT/LT)  | <input type="checkbox"/> Other         |

## MEDICAL NECESSITY

- |   |   |
|---|---|
| <input type="checkbox"/> Negative previous imaging test   | <input type="checkbox"/> Verify injury to any/all 22 cervical ligaments |
| <input type="checkbox"/> Headaches Posterior neck pain  | <input type="checkbox"/> Rule in/ out _____                             |
| <input type="checkbox"/> Dizziness  | <input type="checkbox"/> History of head and neck trauma                |
| <input type="checkbox"/> Blurred vision   | <input type="checkbox"/> Non responsive to current treatment            |
| <input type="checkbox"/> Increased pain with movement   | <input type="checkbox"/> TMJ pain                                       |
| <input type="checkbox"/> Difficulty swallowing  | <input type="checkbox"/> Other _____                                    |
| <input type="checkbox"/> Patient's complaint - (where, when, what relieves etc.)                                  |   |
| <input type="checkbox"/> HX – (recent trauma, surgeries, diseases, cancer, irradiation therapy, weight loss/gain) |   |
| <input type="checkbox"/> Information desired  |   |

DX Code (ICD10) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

## Physician's Additional Notes:



THIS IS MEDICALLY NECESSARY FOR THIS PATIENT

\_\_\_\_\_  
PHYSICIAN NAME

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE