ARIZONA DIGITAL MOTION X-RAY

BRUCE B. LEE, D.C.,MUA-C BILLING ADDRESS: P.O. BOX 14114 MESA, ARIZONA. 85216-4114 (855) 369-7291

DMX Referral

DO NOT WRITE IN THIS SPACE

Date of Report: Date taken:

Patient Information

Patient Name: _____ Date of Birth : _____

Phone: _____ Email: _____

Male / Female Pregnant Yes / No

Ordering Physician Information

Referring Physician: _____ Email _____

Phone: _____ Fax # _____

Address: _____ AZ License #_____

City, State, Zip: _____

Digital Motion X-ray (DMX)

☐ Cervical Spine	☐ TMJ	☐ Wrist (RT/LT)
☐ Shoulder (RT/LT)	☐ Elbow (RT/LT)	☐ Ankle (RT/LT)
☐ Hip (RT/LT)	☐ Knee (RT/LT)	☐ Other

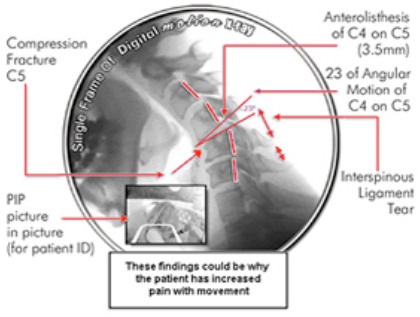
Medical Necessity

☐ Negative previous imaging test	☐ Verify injury to any/all 22 cervical ligaments
☐ Headaches Posterior neck pain	☐ Rule in/ out _____
☐ Dizziness	☐ History of head and neck trauma
☐ Blurred vision	☐ Non responsive to current treatment
☐ Increased pain with movement	☐ TMJ pain
☐ Difficulty swallowing	☐ Other _____

☐ Patient's complaint - (where, when, what relieves etc.)

☐ Hx – (recent trauma, surgeries, diseases, cancer, irradiation therapy, weight loss/gain)

☐ Information desired



☐ **DX Code (ICD10)** _____, _____, _____

Physician's Additional Notes

THIS IS MEDICALLY NECESSARY FOR THIS PATIENT

_____ _____

PHYSICIAN SIGNATURE **DATE**

Fax this form to (855) 255-5478 or email to: orders@dmx-ray1.com