

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: _____ AZ License #: _____

Address: _____

Digital Motion X-ray (DMX) Evaluation for: (choose all that apply)

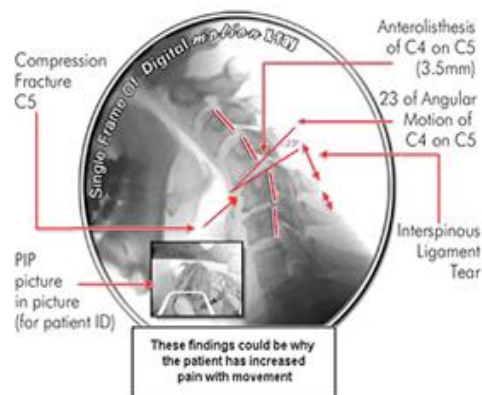
- | | | |
|---|--|--|
| <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> TMJ | <input type="checkbox"/> Wrist (RT/LT) |
| <input type="checkbox"/> Shoulder (RT/LT) | <input type="checkbox"/> Elbow (RT/LT) | <input type="checkbox"/> Ankle (RT/LT) |
| <input type="checkbox"/> Hip (RT/LT)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