Arizona Digital Motion X-ray

AZ|DMX Referral 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: __________________________________ AZ License #: _____________________________

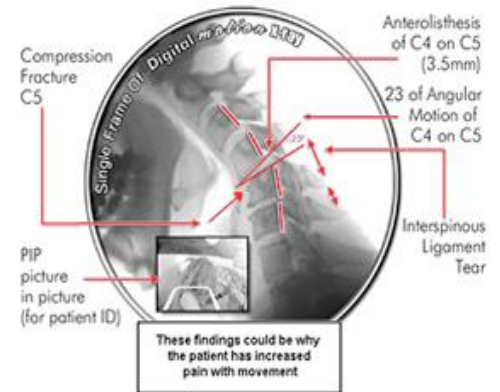
Address: ____

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

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

Medical Necessity

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