Of
Vancouver
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MEDICAL NECESSITY / REFERRAL FOR DMX

DATE:__________________________ **PATIENT NAME:**____

DOB:____**TEL:**____

INSURANCE NAME:____

ADDRESS OF INS:____

CLAIM NO:____**DOI:**________________________________

REFERRING
PHYSICIAN:____**TEL:**___________________________

☐ **Cervical Spine** ☐ **TMJ** ☐ **Shoulder** ☐ **Elbow** ☐ **Wrist** ☐ **Knee**
☐ **Ankle** ☐ **Consultation** ☐ **Exam w/DMX** ☐ **Upper Cervical APOM**

MEDICAL NECESSITY / INDICATIONS FOR DIAGNOSTIC MOTION X-RAY

This assessment of the diagnostic motion x-ray is medically necessary in this specific case, to: Confirm as a direct result of the car crash-related or non-accident-related diagnoses and/or severity with respect to the below conditions which could modify present or future treatment(s) for optimizing the benefits of this patient's care.

☐ Assess: Ligament Instability / Vertebral Derangement /Alteration of Motion Segment Integrity

☐ Help Determine: Grade/Severity of intersegmental motion abnormality (which cannot be determined any other way according to the Guidelines).

☐ Headaches, and/or Dizziness and/or Blurred Vision. ☐ Posterior head and/or neck pain

☐ Referral pain (Scleratomal pain) ☐ Pain Increased w/ Movement

☐ Other________________________________

☐ **Determine (ICD-10):**
☐ **M24.28** **Ligament Laxity**
☐ **M53.2X1** **Instability of Occipitoatlantoaxial Spine**
☐ **M53.82** **Cervical Facet Syndrome.**

PHYSICIAN'S SIGNATURE:____**Date:**_________________
I certify that my clinic utilizes HIPAA compliant consent and notice of privacy practices in association with any disclosures of patient information to you:

Freeman, M.D., Katz, E.A., Rosa, S.L., Gatterman, B.G., Strommer, E.M.F., & Leith, W.M. (2020). Diagnostic Accuracy of Videofluoroscopy for Symptomatic Cervical Spine Injury Following Whiplash Trauma. *Int. J. Environ. Res. Public Health, (17*), 1693.