PINNACLE DMX
DIGITAL MOTION IMAGING

Diagnostic Fluoroscopic Imaging Procedure (DMX)

Date:_____ Referring Physician:_____
Phone:_____ Fax:_____ Email:_____
Patient:_____ Phone: _____ DOB:_____
Address:_____ City:_____ State: _____ Zip: _____
DOA:_____ Insurance:_____ Claim #:_____
Attorney _____ Phone:_____ Fax: _____
Email: _____ Address:_____

Region(s) Requested:

- ☐ SHOULDER (RT / LT)
- ☐ WRIST (RT / LT)
- ☐ CERVICAL SPINE
- ☐ TMJ
- ☐ KNEE (RT / LT)
- ☐ ANKLE (RT / LT)
- ☐ LUMBAR SPINE
- ☐ HIP (RT / LT)
- ☐ ELBOW (RT / LT)
- ☐ OTHER:_____

Symptoms and Findings: (CHECK ANY THAT APPLY)

Primary Classic Symptoms:

- ☐ HEADACHES
- ☐ POSTERIOR NECK PAIN
- ☐ REFERRED UPPER BACK PAIN
- ☐ REFERRED SHOULDER PAIN
- ☐ INCREASED PAIN W/ MOVEMENT
- ☐ SCLERATOMAL PAIN
- ☐ POPPING/CLICKING SOUND W/ MOVEMENT
- ☐ OTHER:_____

Secondary Classic Symptoms:

- ☐ DIZZINESS
- ☐ BLURRED VISION
- ☐ DIFFICULTY SWALLOWING
- ☐ MUSCLE SPASMS

Classic X-ray Findings:

- ☐ TRANSLATION OR ANGULATION OF ONE OR MORE VERTEBRA
- ☐ SUBLUXATION REVERSED OR STRAIGHTENED CURVATURE

Medical Rationale(s) for Diagnostic Fluoroscopic Imaging Procedure (DMX)

- ☐ Confirm injury diagnoses and/or severity with respect to the below conditions which could modify my present or future treatment plan for optimizing the benefits of care:
  - ☐ Rule out Ligamentous injury and resulting instability in the upper third of cervical spine (an area held together primarily by ligaments and containing no discs) **(Primary Ligament(s) Involved: Alar, Accessory, Transverse)**
  - ☐ Rule out Ligamentous injury and resulting instability associated with the facet joints located in the lower two-thirds of the cervical spine. **(Primary Ligament(s) Involved: Capsular)**
  - ☐ Rule out Ligamentous injury and resulting instability in the entire cervical spine. **(Primary Ligament(s) Involved: Anterior Longitudinal, Posterior Longitudinal, Interspinous)**
- ☐ Rule out undiagnosed fracture and/or any additional variants given the nature of the accident.
- ☐ Other:_____

DX Code (ICD10) _____, _____, _____, _____, _____,

Physician's Signature: _____

Notes: _____

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