



Clinical Analysis & AMA imaging Measurements

CIAAiM Request Form (Cervical Spine)

Tel: (714)284-0111 | Fax: 800-637-5254

1. PATIENT INFORMATION

Name: _____ SSN: _____
 DOB: _____ DOI: _____
 Sex: Male Female

2. PATIENT'S DIAGNOSIS RELATED TO THIS INJURY _____ **DATE OF INITIAL WORKERS' COMPENSATION INJURY** _____

3. CURRENT CLINICAL SYMPTOMS & SIGNS
 Please base your answers to the questions below on the most current clinical exam. (Reference p 382-3, AMA Guidelines 5th edition.)

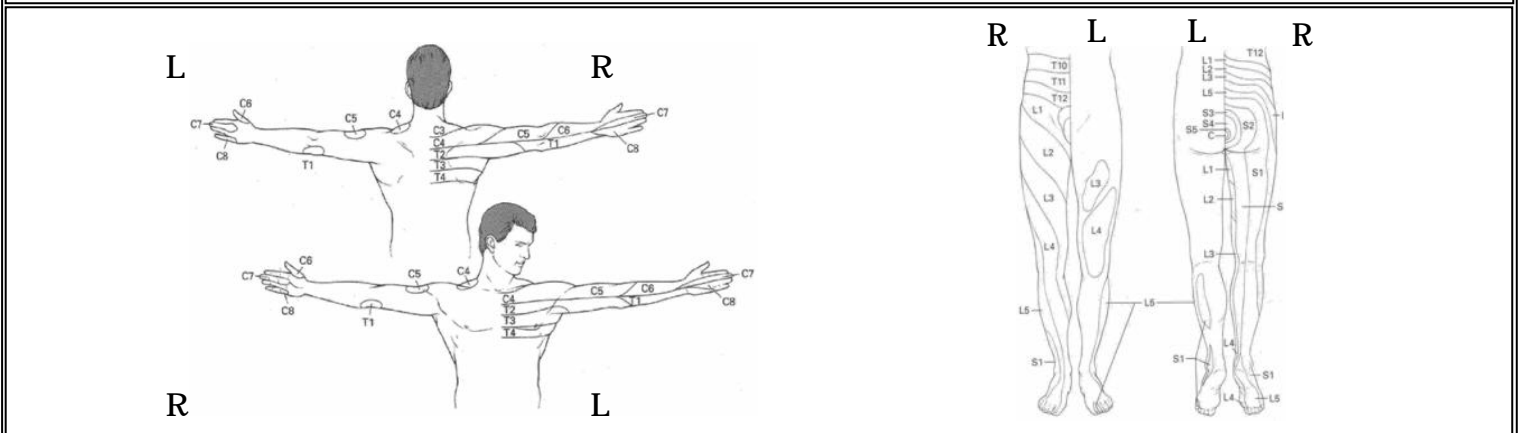
A) Yes No Are there current muscle spasms present? If yes, please indicate side and paraspinal level(s) _____

B) Yes No Is there current muscle guarding present? If yes, please indicate side and paraspinal level(s) _____

C) Yes No Is there current asymmetrical spinal motion? If yes, please level(s) _____

4. NEUROLOGICAL EXAM (Reference: 376 table 15-2; AMA Guidelines 5th edition.)

	Motor Exam Key						Deep Tendon Reflexes Key																				
	0 - No contractions 1 - Slight contractions 2 - Active movement with gravity eliminated 3 - Active movement against gravity only 4 - Active movement against gravity and some resistance 5 - Active movement against gravity and full resistance Please select appropriate grade on chart below.						0 - No response 1 - Hyporeflexia 2 - Normal 3 - Hyperreflexia 4 - Hyperreflexia with transient clonus 5 - Hyperreflexia with sustained clonus Please select appropriate grade on chart below.																				
	Deficit	Left		Right		Deficit	Left		Right																		
Upper Extremities	C5	Deltoid	0	1	2	3	4	5	0	1	2	3	4	5	Biceps	0	1	2	3	4	5	0	1	2	3	4	5
	C6	Wrist extensors	0	1	2	3	4	5	0	1	2	3	4	5	Brachioradialis	0	1	2	3	4	5	0	1	2	3	4	5
		Biceps	0	1	2	3	4	5	0	1	2	3	4	5		0	1	2	3	4	5						
	C7	Triceps	0	1	2	3	4	5	0	1	2	3	4	5	Triceps	0	1	2	3	4	5	0	1	2	3	4	5
	C8	Finger flexors	0	1	2	3	4	5	0	1	2	3	4	5													
T1	Hand intrinsics;	0	1	2	3	4	5	0	1	2	3	4	5														
Lower Ext.	L4	Quadriceps	0	1	2	3	4	5	0	1	2	3	4	5	Knee	0	1	2	3	4	5	0	1	2	3	4	5
	L5	Extensor hallucis longus	0	1	2	3	4	5	0	1	2	3	4	5	Medial hamstrings	0	1	2	3	4	5	0	1	2	3	4	5
	S1	Ankle plantar flexors	0	1	2	3	4	5	0	1	2	3	4	5	Ankle	0	1	2	3	4	5	0	1	2	3	4	5

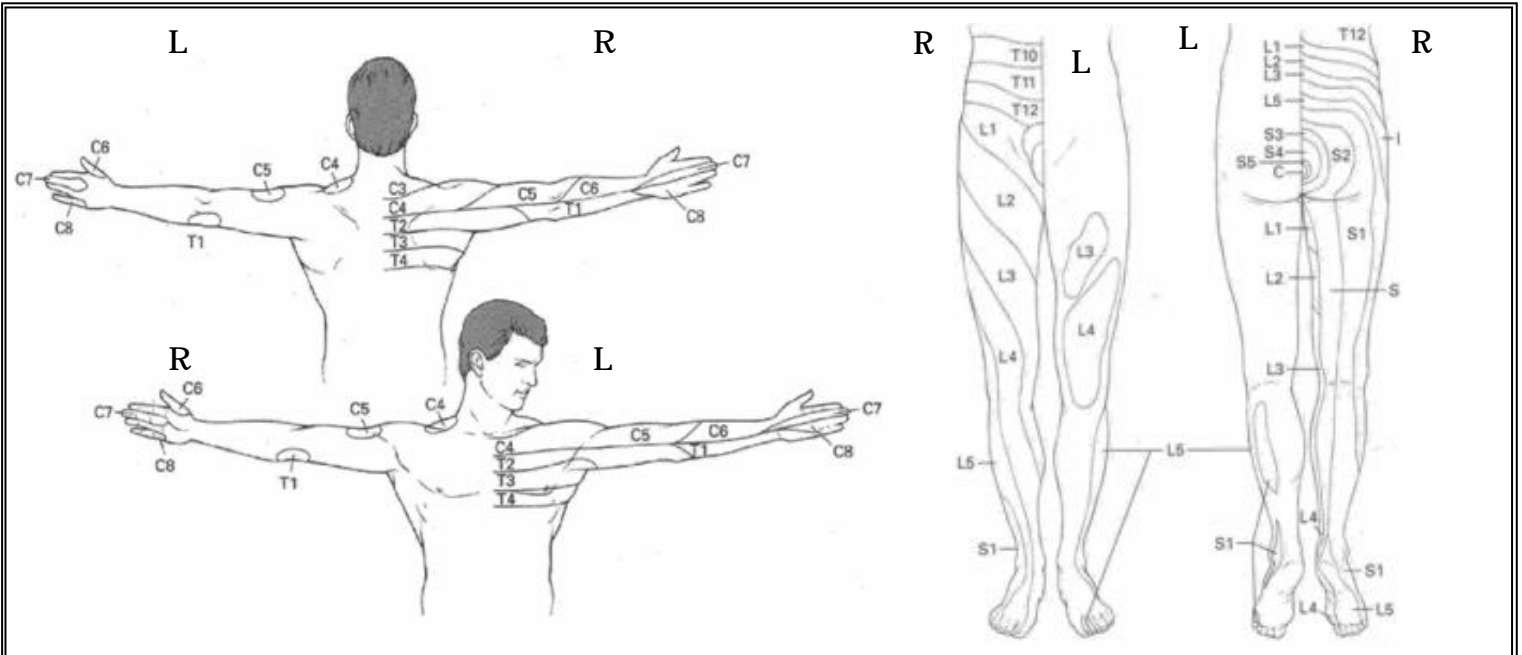




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5. SENSORY EXAM

Sensory: Please list any sensory abnormalities below using the sensory scale below, (Reference: 376 table 15-2 AMA Guidelines 5th edition.)

- Grade 0 = Absent sensibility, abnormal sensations, or severe pain that prevents all activity
- Grade 1 = Deep cutaneous sensibility present; absent superficial pain and tactile sensibility (absent protective sensibility), with abnormal sensations or severe pain, that prevents most activity
- Grade 2 = Decreased cutaneous and tactile sensibility (decreased protective sensibility), with abnormal sensations or slight pain, that interferes with some activities
- Grade 3 = Distorted superficial tactile sensibility (diminished light touch and two-point discrimination), with abnormal sensations or slight pain, that interferes with some activities
- Grade 4 = Distorted superficial tactile sensibility (diminished light touch), with or without minimal abnormal sensations or pain, that is forgotten during activity
- Grade 5 = No loss of sensibility or abnormal sensation, or pain

All Normal(Grade 5)

If sensory is Abnormal please list Grade, Side and Dermatome level

Grade	Side	Dermatome Level	Grade	Side	Dermatome Level
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

6. MUSCLE ATROPHY

Is there current extremity muscle atrophy(>2cm diameter difference in the thigh or 1cm diameter difference to the arm, forearm or calf circumference from contralateral side) If yes, please list the side and dermatome level.

7. RADICULAR PAIN

Does the patient at MMI exhibit Radicular pain that follows a dermatome pattern?

Yes

1. Single level Unilateral Radicular pain. Please indicate side and dermatome level. _____
 Verified Non- Verified*
2. Single level Bilateral Radicular pain. Please indicate side and dermatome level. _____
 Verified Non- Verified*
3. Multiple levels of Radicular pain. Please indicate side and dermatome level(s). Verified _____
 Non- Verified*

No

1. Did the patient previously have Radicular pain that followed a dermatome pattern and was resolved by non surgical treatment during this case?
 Yes No
2. Did the patient previously have Radicular pain that followed a dermatome pattern and was resolved by surgical means during the case?
 Yes No
3. Patient never had Radicular pain that followed a dermatome pattern during the case?
 Yes

* **Non Verified** Pain is a pain that is in the distribution of a nerve root **but has no** identifiable origin, that is there are no objective clinical, imaging or electromyographic findings to explain the origin of the pain.

Pursuant to title 8, California code of regulations, 9875(l), notification is hereby given that based on this patient's examination, history and diagnosis, in my professional opinion these tests and reports are medically necessary for evaluating permanent impairment in all workers compensation cases, pursuant to SB899, this exam order is consistent with the administrative director's medical practice guidelines.

Ordering Physician's Name (print)

Ordering Physician's Signature

Date



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Cervical Spine

Movement	Description	Range
Cervical flexion	Calvarium angle	
	T1 ROM	
	Cervical flexion angle ± 10% or 5°	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Maximum cervical flexion angle	Is the difference of the above measurements within a 10% or 5 difference of each other.
Cervical extension	Calvarium angle	
	T1 ROM	
	Cervical flexion angle ± 10% or 5° difference	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Maximum cervical flexion angle	Is the difference of the above measurements within a 10% or 5 difference of each other.
Cervical Ankylosis in flexion/extension	Position	(Excludes any impairment for abnormal flexion or extension motion)
Cervical left lateral bending	Calvarium angle	
	T1 ROM	
	Cervical left lateral flexion angle ± 10% or 5° difference	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Maximum cervical left lateral flexion angle	Is the difference of the above measurements within a 10% or 5° difference of each other.
Cervical right lateral bending	Calvarium angle	
	T1 ROM	
	Cervical right lateral flexion angle ± 10% or 5° difference	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Maximum cervical right lateral flexion angle	Is the difference of the above measurements within a 10% or 5° difference of each other.
Cervical Ankylosis in lateral bending	Position	(Excludes any impairment for abnormal flexion or extension motion)
Cervical left rotation	Cervical left rotation angle ± 10% or 5° difference	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Maximum cervical left rotation angle	Is the difference of the above measurements within a 10% or 5° difference of each other.
Cervical right rotation	Cervical right rotation angle ± 10% or 5° difference	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Maximum cervical right rotation angle	Is the difference of the above measurements within a 10% or 5° difference of each other.
Cervical Ankylosis in rotation	Position	(Excludes any impairment for abnormal flexion or extension motion)

Landmarks for ROM = Top of Head and T1