Participants with Down Syndrome

Client Name: ____ Date of Birth: ______________

AtlantoDens Interval X-rays, date: ________________________________ _ Result: positive negative

Neurological Symptoms of Atlantoaxial Instability: ____

A physical examination of ____ on ___________________

did not reveal atlantoaxial instability or focal neurologic disorder.

_________________________________ _________________

Physician Signature Date

____

Physician Name (Printed)