

**UW Hospital and Clinics
Musculoskeletal Radiology Spine Injections
Screening Sheet and Exam Requested**

Fax to 608-263-9559 For scheduling, call 261-1615 or 263-XRAY

PATIENT NAME:	MR#:
BIRTH DATE:	WEIGHT (LBS):
APPOINTMENT DATE AND TIME:	
ORDERING PHYSICIAN:	TELEPHONE:
DIAGNOSIS/HISTORY:	
SCREENER SIGNATURE:	SCREENING DATE:

YES NO

- Previous spine MRI/CT: UW_____ Outside_____ (if outside scan, have patient bring scan to injection apptmt)
- Spine surgery within the last 12 weeks or since most recent MRI/CT scan
- Currently taking anticoagulants:_____ aspirin: _____ NSAIDS:_____
- Any evidence of infection in the body
- Allergic to x-ray contrast (iodine)
- Special considerations _____
- Approved for 3 consecutive injections as needed

PROCEDURE REQUESTED

Same as last time (or check below)

Midline (translaminar) epidural

Preferred level if possible:

- Radiologist preference
- L2/3
- L3/4
- L4/5
- Caudal/Sacral
- Cervical
- Other _____

Trans-foraminal epidural

-or-

Selective nerve root block

- | | |
|--|--|
| <input type="checkbox"/> Right
<input type="checkbox"/> Both
<input type="checkbox"/> Left | <input type="checkbox"/> L2/3 foramen-L2 root
<input type="checkbox"/> L3/4 foramen-L3 root
<input type="checkbox"/> L4/5 foramen-L4 root
<input type="checkbox"/> L5/S1 foramen-L5 root
<input type="checkbox"/> S1 root

<input type="checkbox"/> C4/5 foramen-C5 root
<input type="checkbox"/> C5/6 foramen-C6 root
<input type="checkbox"/> C6/7 foramen-C7 root
<input type="checkbox"/> C7/T1 foramen-C8 root
<input type="checkbox"/> Other _____ |
|--|--|

Discogram

Levels to test (usually 3):

- L5/S1
- L4/5
- L3/4
- L2/3
- L1/2
- Other _____

Sacroiliac joint injection

- Right
- Left

Facet injection

- Right
- Left
- Level:
- L3/4
- L4/5
- L5/S1
- Other _____