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**

- ☐ Right
- ☐ Both
- ☐ Left

- ☐ L2/3 foramen-L2 root
- ☐ L3/4 foramen-L3 root
- ☐ L4/5 foramen-L4 root
- ☐ L5/S1 foramen-L5 root
- ☐ S1 root
- ☐ C4/5 foramen-C5 root
- ☐ C5/6 foramen-C6 root
- ☐ C6/7 foramen-C7 root
- ☐ C7/T1 foramen-C8 root
- ☐ 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_____

KWD 10/05/07