HOSPITAL FOR **SPECIAL SURGERY**

DEPARTMENT OF RADIOLOGY AND IMAGING

Spine Procedure Scheduling Form

Please ask the patient to bring any outside films with them

Referring office must communicate appointment time to patient

Patient name: _____ MRN: _____ Phone: _____

Referring MD: _____ Phone: _____ Fax: _____

Is the patient anticoagulated?	No	Yes
Is there any h/o contrast reaction?	No	Yes
Prior back surgery?	No	Yes

(____) **Myelogram** Cervical☐ Thoracic☐ Lumbar☐

(____) **Nonselective Lumbar Epidural Injection** (indicate level, if appropriate)

(____) **Sacroiliac Joint Injection** (Choose side) right left

(____) **Discogram** (select levels) T12-L1 L1-2 L2-3 L3-4 L4-5 L5-S1

(____) **Selective Nerve Root w/ Steroid Injection**
(1 cervical or 2 lumbar sites per visit)

Site #1
Side (circle one): right left
Select nerve (eg. C5, L4, S1) _____

Site #2 Side (circle one): right left
Select nerve (C5, L4, and S1)_____

(_____) **Facet Block w/Steroid Injection** (2 sites per visit)

Site #1:
Side (circle one): right left
Select level (e.g. C4-5, L4-5): _____

Site #2
Side (circle one): right left
Select level (e.g. C4-5, L4-5)

The patient should report to Radiology reception on the 3rd floor

Date: _____ Time: _____

CONFIRMATION: NAME: DATE: BY: PHONE FAX: _____

535 East 70th Street, New York, NY 10021 Tel-(212) 606-1258 Fax- (212) 737-0946