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: _____

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