



DEPARTMENT OF RADIOLOGY MUSCULOSKELETAL IMAGING REQUEST FORM

Please Fax to (434) 243-6999
Schedule at (434) 243-6888

PLACE LABEL HERE

Ordering Date _____

SS# _____

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

Patient Name: _____ MR# _____

Pre/Post-op Y N Date of Surgery _____ Date of Test _____

DOB _____ / _____ / _____ Weight: _____ Pt Phone # _____

Insurance Company & Plan	Pre Authorization Number	Attending MD/Pic #	Ordering MD/Pic #
Office Where Report Should Be Sent	Phone Number of Contact Person Name	Box & Fax Number	

Clinical Indications for Exam:

Relevant Signs/Symptoms Diagnosis (MANDATORY–MUST be ICD-9 Numeric Code):

STUDY DESIRED

X	Study	X	Study
	<i>Skull & Facial Bones</i>		<i>Upper Extremity</i>
	Skull PA/LAT		Humerus AP/LAT R L
	Orbits for MRI screening PA/LAT		Elbow AP/LAT R L
	Nasal Bones/waters hard/soft LAT		Elbow AP/LAT/Axial R L
	<i>Thorax/Abdominal</i>		Elbow AP/LAT/OBL R L
	Chest PA		Axial View Elbow R L
	Chest PA/LAT		Forearm AP/LAT R L
	Sternum LAT		Wrist PA/LAT R L
	Sternum OBL		Wrist PA/LAT/OBLS R L
	Ribs AP/OB/PA CXR R L		Wrist PA/LAT/Navicular R L
	Ribs AP/OBL R L		Wrist Carpal Tunnel R L
	Abdomen Single View		Wrist 6 Views R L
	Abdomen Flat and upright		Wrist radial/ulnar deviation R L
	Other (Specify)		Wrist closed fist views R L
	<i>Shoulder Girdle</i>		Hand PA/LAT (inclds wrist) R L
	Shoulder AP/LAT Axillary R L		Hand Bilateral PA on 1 film R L
	Shoulder Internal/External R L		Finger PA/LAT/OBL (Which digit) R L
	Shoulder AP/Scapular Y view(neer) R L		Finger 1 or 2 views (specify digit) R L
	Shoulder AP/Outlet/Axillary R L		U Extrm infant (incld humeri & forearm) R L
	Shoulder Axillary R L		
	Shoulder Acromion Y/Outlet R L		
	Shoulder West Point R L		
	Shoulder 30 Caudal R L		
	Shoulder AP LAT/Axillary/Acromion Y R L		
	Shoulder AP/Outlet/Axillary/30 Caudal R L		
	Clavicle AP/Tangential R L		
	Scapula AP/LAT R L		

If films were taken within 2 weeks prior to scan from outside UVA please instruct pt to bring films.

Are there any special considerations for pts safety? (e.g. non-english speaking, sz disorder, pregnancy, M.R., medications that could affect pt. Testing) Explain: _____

Does patient require early reading? Yes No Films to Go with Patient After Reading? Yes No

Physician Signature: _____

MUSCULOSKELETAL IMAGING REQUEST



DEPARTMENT OF RADIOLOGY MUSCULOSKELETAL IMAGING REQUEST FORM

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PLACE LABEL HERE

Ordering Date _____

SS# _____
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

M Patient Name: _____ MR# _____

U Pre/Post-op Y N Date of Surgery _____ Date of Test _____

S DOB _____ / _____ / _____ Weight: _____ Pt Phone # _____

Insurance Company & Plan	Pre Authorization Number	Attending MD/Pic #	Ordering MD/Pic #
Office Where Report Should Be Sent	Phone Number of Contact Person Name	Box & Fax Number	

Clinical Indications for Exam (Mandatory):

Relevant Signs/Symptoms Diagnosis (MANDATORY–MUST be ICD-9 Numeric Code):

STUDY DESIRED

X	Study	X	Study
	<i>Spines</i>		Hip FROG Lat R L
	C-Spine AP/LAT/ODONTOID		Hip JUDET Views (45 Deg Obl) R L
	C-Spine AP/LAT		Other (specify) R L
	C-Spine FLEX/EXT only		<i>Lower Extremity</i>
	C-Spine AP/LAT/FLEX/EXT		Femur AP/Lat R L
	C-Spine AP/LAT/OBL/FLEX/EXT		Knee PA/Lat R L
	C-Spine AP/LAT/OBLS		Knee PA/Lat/Tunnel/Patellar (Sunrise) R L
	C-Spine Lateral/Flex/EXT		Knee PA/Lat/Obliques R L
	C/T Spine (swimmers)		Knee Standing Flex/Lat/Sunrise R L
	T-Spine AP/LAT		Knee PA/LAT/Sunrise R L
	T-Spine AP/LAT, swimmers		Knee PA/LAT/Tunnel R L
	T-L Spine junction AP & LAT		Tunnel/Lateral/Sunrise R L
	L-Spine AP/LAT		Sunrise View Only R L
	L-Spine AP/LAT/OBLS		Knee Standing Only R L
	L-Spine AP/LAT/OBLS/FLEX & EXT		Knee Standing 30/45 flexion R L
	L-Spine FLEX/EXT		Knee LAT R L
	L-Spine Lateral/FLEX/EXT		Knee standing Hip to Ankle/3 ft Cassette R L
	Sacrum Coccyx AP/LAT		Lower ext. infant (includes femur & tib/fib) R L
	Scoliosis films AP/LAT (standing)		Tibia/Fibula AP/LAT R L
	Scoliosis films supine/erect/side bending		Ankle AP/LAT R L
	<i>Pelvis / Hips</i>		ANKLE AP/LAT/Mortise R L
	Pelvis AP/Bilateral Hips (1 film)		Ankle Stress Views R L
	Pelvis Inlet/Outlet views		Broders R L
	Pelvis/Hips Infant		Calcaneus LAT/Axial R L
	Pelvis AP/OR Lat Hip R L		Foot AP/LAT R L
	Pelvis AP/FROG Lat Hip R L		Foot AP/LAT/Oblique R L
	Hip AP/OR Lat R L		Foot Standing AP/LAT R L
	Hip AP/FROG Lat R L		Foot Standing AP/LAT/Oblique R L
	Hip OR Lat R L		Toe AP/LAT/Obl (specify which toe)
			Scanogram

Physician Signature: _____

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