



# 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
	<b><i>Skull &amp; Facial Bones</i></b>		<b><i>Upper Extremity</i></b>
	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
	<b><i>Thorax/Abdominal</i></b>		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
	<b><i>Shoulder Girdle</i></b>		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



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

**Physician Signature:** \_\_\_\_\_

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