ASPIRUS IMAGING CENTER - WESTHILL

SPINE PROCEDURE SCHEDULING

Patient name: _____ DOB: _____ Phone: _____

Referring MD: _____ Phone: _____ Fax: _____

Pain symptoms: _____

_____

Is the patient anticoagulated?	No	Yes	(then consider holding for 3-5 days, except for NSAIDS)
Is there any h/o contrast reaction?	No	Yes	(then consider pre-medication)
Is the patient a diabetic?	No	Yes	(then anticipate possible elevation in serum glucose)
Is the patient wheelchair dependent?	No	Yes	(then pls. notify scheduler)
Contact precautions (for MRSA/VRE)?	No	Yes	(then pls. notify scheduler)
Prior spine surgery?	No	Yes,	please describe:

(___) **Lumbar Epidural Steroid Injection** (indicate level, if appropriate)

(___) **Sacroiliac Joint Injection** (choose side) right left

(___) **Lumbar Discogram** (select levels) L2-3 L3-4 L4-5 L5-S1

(___) **Selective Nerve Root Block with Steroid Injection**

Site #1:

Side (circle one): right left

Select nerve (eg. C5, L4, S1): _____

Site #2:

Side (circle one): right left

Select nerve (eg. C5, L4, S1): _____

(___) **Facet Block with Steroid Injection**

Site #1:

Side (circle one): right left

Select level (eg. C4-5, L4-5): _____

Site #2:

Side (circle one): right left

Select level (eg. C4-5, L4-5): _____

(___) **Other procedures (arthrograms/joint injections, bursal injections, trigger point injections, RFA)**

Specify procedure and location _____

The patient should report to Aspirus Imaging Westhill (3200 Westhill Drive) and have a companion present to drive home. NPO for 3 hours prior to the procedure EXCEPT for meds and water.
Please ask the patient to bring available outside films.

Important phone numbers: Scheduling - 715-847-2020; Please FAX this form to 715-847-0078 / Attn:Scheduling

SCHEDULED DATE: _____ **and TIME:** _____

Ordering MD Signature:_____**Date**_____