Patient Identification	VCU Health System MCV Hospitals and Physicians Richmond, Virginia 23298
Name : **MR#:** **Date:** **Phone #:**	**RADIOLOGY ORDER** **Musculoskeletal Procedures**

*Please fax this **signed** form to (804) 327-8847 (Attn: MSK Scheduling), and then send a copy of the form with patient to appointment.*
Musculoskeletal Radiology: Main 3# 804-628-1975; St Point# 804-327-8835; fax# 804-237-6634

Patient's Alternate Contact Number: _____

Current Medications: _____

_____

Currently Taking Blood Thinners? _____ If yes, name? _____

***** Patients on blood thinners must discontinue medications for five days prior to procedure***

Contrast/Medication/Food Allergies? _____ If yes, name? _____

***** Patients with contrast/dye allergies must contact the MSK section prior to scheduling.***

Pertinent Patient History _____

_____

Referring Physician _____ Office Number _____

EXTREMITY PROCEDURES

ICD-9 CODE: _____

		Hand	Wrist	Elbow	Hip	Knee	Shoulder	Foot	Ankle
Arthrogram	❑ Conventional	R L	R L	R L	R L	R L	R L	R L	R L
	❑ MR to follow arthrogram	R L	R L	R L	R L	R L	R L	R L	R L
	❑ CT to follow arthrogram	R L	R L	R L	R L	R L	R L	R L	R L

		Hand	Wrist	Elbow	Hip	Knee	Shoulder	Foot	Ankle
Joint Injection	❑ Marcaine	R L	R L	R L	R L	R L	R L	R L	R L
	❑ Steroid	R L	R L	R L	R L	R L	R L	R L	R L

		Hand	Wrist	Elbow	Hip	Knee	Shoulder	Foot	Ankle
Joint Aspiration	❑ Culture & Sensitivity	R L	R L	R L	R L	R L	R L	R L	R L
	❑ Cell Count	R L	R L	R L	R L	R L	R L	R L	R L
	❑ Fluid Analysis-Crystals	R L	R L	R L	R L	R L	R L	R L	R L

SPINE PROCEDURES

*****All patients receiving an Epidural Injections (Interlaminar or Selective) must have a recent (within past two years) L-spine MRI or CT before procedure can be scheduled***

❑ Epidural Steroid Injection** (Interlaminar)	
❑ Epidural Steroid Injection** (Transforaminal/Selective Nerve Root)	➢ L1 Nerve (L1-2 foramen) R L ➢ L2 Nerve (L2-3 foramen) R L ➢ L3 Nerve (L3-4 foramen) R L ➢ L4 Nerve (L4-5 foramen) R L ➢ L5 Nerve (L5-S1 foramen) R L ➢ S1 Nerve (S1 foramen) R L
❑ Facet Injections	➢ L 1-2 R L ➢ L 2-3 R L ➢ L 3-4 R L ➢ L 4-5 R L ➢ L 5-S1 R L
❑ Sacroiliac (SI) Joint Injection	(Please specify side)

BONE/SOFT TISSUE BIOPSIES *Please contact Kim Williams at (804) 827-4787 to schedule MSK biopsies.

PHYSICIAN SIGNATURE: _____ (required) **DATE**: _____

Person Scheduling Procedure(required) _____

Contact Phone & Fax Numbers _____