NAME: **MR#**: **DOB**: **Phone #**:	**VCU Health System** MCV Hospitals and Physicians Richmond, Virginia 23298 **Musculoskeletal Procedure Request/Order**

Contact Information: VCU Stony Point MSK: (804) 237-6619 VCU Downtown MSK: (804) 827-4787

Fax **signed** form to **(804) 327-8847** (Attn: Stony Point MSK Scheduling), or **(804) 828-5570** (Attn: Downtown Scheduling)

Current Medications: _____

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

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

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

**** 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	R L	R L	R L	R L	R L	R L	R L	R L
	❑ CT	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)

(Note: Federal regulations require a physician's signature)

Physician Signature:_____ **Pager**:_____

Physician Printed Name:_____ **Date**:_____