# CT Lumbar Spine Checklist

*Please complete the checklist for all adult (18+) outpatient lumbar spine referrals and include this Checklist with the CT requisition.* *(Note: the Checklist is a draft document, pending feedback from users)*

*Patient label placed here, or minimum information below required*

**Patient Name:**
**Date:**
**Age:**
**Gender:**
**HSN:**

| **Was this test discussed with, or recommended by a specialist or radiologist?** | ☐ Yes<br>☐ No or N/A |
|---|---|

**Suspected or Known Conditions**

| ☐ **Tumor of vertebra or bone** | ☐ **Trauma/Suspected lumbar fracture** | ☐ **Prior lumbar surgery** |
|---|---|---|

☐ **Other Indication** *(Please specify)*:

☐ **Lumbar Spine MRI is Contraindicated** *(Please specify reason for contraindication)*

**<u>The information below is required ONLY if Lumbar Spine MRI is contraindicated and the patient requires a Lumbar Spine CT</u> :**

**Red Flags** *(Please immediately call radiologist if any of these symptoms are present)*

| ☐ **Suspected cancer including metastasis** | ☐ **Suspected cauda equina syndrome** *(i.e. urinary incontinence, urinary retention)* | ☐ **Suspected infection** *(i.e. osteomyelitis, discitis, steroid use, IV drug use, immunosuppression)* | ☐ **Severe or progressive neurologic deficit** |
|---|---|---|---|

**Mechanical Back Pain**
with symptoms persisting or worsening despite **conservative management for at least 6 weeks** *(Check all that apply)*

| ☐ **Low back pain for at least 6 months (Pattern 1 & 2)** | ☐ **Radiculopathy for at least 6 weeks (Pattern 3)** | ☐ **Spinal stenosis symptoms for at least 6 weeks (Pattern 4)** |
|---|---|---|

**Suspected or Known Conditions** *(Check all that apply)*

| ☐ **Spinal dysraphism** *(open or closed)* | ☐ **Treatment fields for radiation therapy** | ☐ **Ankylosing spondylitis** |
|---|---|---|
| ☐ **Evaluation of scoliosis** *(preoperative assessment, any neurologic findings, atypical curve pattern, congenital scoliosis, neurofibromatosis, Marfan's syndrome)* | ☐ **Pre-procedure kyphoplasty** | ☐ **Suspected epidural abscess or hematoma** |
| ☐ **Spinal cord lesion or possible cord compression** | ☐ **Post-operative collections** *(soft tissue or fluid)* | ☐ **Arachnoiditis** |
| ☐ **Intradural tumor** *(hyperreflexia, LE weakness, spasticity, bladder/bowel dysfunction, sensory loss, new onset scoliosis/kyphosis, spastic gait, radiculopathy, localized spine tenderness, pain, CSF positive for malignant cells – with or without history of cancer)* | | |

**Other Patient Information and Comments** (Patient history, information for radiologists, comments about the Checklist)

*(Version 4 Revised March 6, 2017)*