CT SPINE APPROPRIATENESS CHECKLIST

Patient label placed here, or minimum information below required

This checklist is based on the **Choosing Wisely** *criteria and the* **CORE Back Tool**. *It is required for all adult (18+) outpatient CT spine referrals.* ***Please include with CT requisition. For most clinical concerns, CT should be ordered only if there is an MRI contraindication as MRI is superior to CT. Exceptions include suspected fracture, further characterization of known bone lesion, pre-surgical or post-surgical assessment.***

Patient Name: _____
Date (YYYY-MM-DD): _____
Date of Birth (YYYY-MM-DD): _____
Gender: _____
Health Card #: _____

Referring Physician Name: _____

A. Red Flags requiring Emergent Management (immediate CT and consultation to Surgery)
(consider sending patient to Emergency Department)

- ☐ Severe/Progressive Neurologic Deficit
- ☐ Cord Compression or Cauda Equina Syndrome

B. Red Flags requiring Urgent CT (immediate radiology consultation recommended)

- ☐ Suspected Cancer
- ☐ Suspected Spinal Infection
- ☐ Suspected Epidural Abscess or Hematoma
- ☐ Suspected Fracture

C. Mechanical Spine Pain Syndrome with no Red Flags requiring Non-Urgent CT
(Check all that apply – there MUST be a check in sections 1, 2, and 3 below to meet imaging criteria)

1. ☐ Unbearable Arm or Leg Dominant Pain *(and/or)* ☐ Disabling Neurogenic Claudication *(and/or)* ☐ Functionally Significant Neurologic Deficit

2. ☐ Failure to Respond after 6 weeks of conservative care

3. ☐ Considering Surgery

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

- ☐ Cancer *(please specify)*
- ☐ Intradural Tumour
- ☐ Bone Tumour or Metastases
- ☐ Congenital Spine Anomaly
- ☐ Scoliosis
- ☐ Spinal Radiation
- ☐ Demyelination or MS
- ☐ Inflammatory Disease
- ☐ Assessment for Vertebroplasty
- ☐ Prior Spine Surgery *(date)*
- ☐ Arachnoiditis
- ☐ Post-operative Collections
- ☐ Follow-up for a Known Condition *(please specify)*
- ☐ Condition Not Listed *(please specify)*

Prior CT or MRI Spine Imaging (Select one)

☐ CT ☐ MRI

When: _____ Where: _____

Additional Clinical Information

Please provide any additional information below. Please also clearly indicate the affected area on the image to the right.