

*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 label placed here, or minimum information below required*

**Patient Name:**  
**Date (YYYY-MM-DD):**  
**Date of Birth (YYYY-MM-DD):**  
**Gender:**  
**Health Care #:**

Referring Physician Name:

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

<input type="checkbox"/> Severe/Progressive Neurologic Deficit	<input type="checkbox"/> Cord Compression or Cauda Equina Syndrome
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**B. Red Flags requiring Urgent CT (immediate radiology consultation recommended)**

<input type="checkbox"/> Suspected Cancer	<input type="checkbox"/> Suspected Spinal Infection	<input type="checkbox"/> Suspected Epidural Abscess or Hematoma
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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 *(and/or)* or Leg Dominant Pain     
  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)**

<input type="checkbox"/> Cancer <i>(please specify)</i>	<input type="checkbox"/> Intradural Tumour	<input type="checkbox"/> Bone Tumour or Metastases
<input type="checkbox"/> Congenital Spine Anomaly	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Spinal Radiation
<input type="checkbox"/> Demyelination or MS	<input type="checkbox"/> Inflammatory Disease	<input type="checkbox"/> Assessment for Vertebroplasty
<input type="checkbox"/> Prior Spine Surgery <i>(date)</i>	<input type="checkbox"/> Arachnoiditis	<input type="checkbox"/> Post-operative Collections
<input type="checkbox"/> Follow-up for a Known Condition <i>(please specify)</i>		
<input type="checkbox"/> Condition Not Listed <i>(please specify)</i>		

**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.

