Lumbar Spine MRI/CT Report Format  
Spring, 2015

**EXAM TITLE:** MRI (1.5T, 3T, 1.2T Open, 0.6T Open Upright) or CT use of contrast and/or sedation. Designate limited exam if applies.

**CLINICAL INFORMATION:** Patient symptoms, history of previous surgery, cancer or infection, and specific clinical questions if indicated by the referring provider.

**TECHNIQUE:**  
Sequences, planes, reformations and anatomic areas imaged;  
Contrast volume, type and route of administration;  
Sedation with dose, medication and reference to monitoring with pulse oximetry;  
Any patient reactions or complications during or following the exam; and potential limitations, commenting on factors that may degrade the quality of the scan.

**COMPARISON:** (Date and type of exam)

**INTERPRETATION:** General statement concerning alignment (hyperlordosis, scoliosis, no spondylolisthesis or spondylolysis etc.). Limited visualization of the sacrum with findings.

L5-S1:
- **Grade disc and facet degeneration.**
- **Surgical changes** if present.
- **Spondylolysis and/or Spondylolisthesis** if present (degenerative v. spondylolytic, grade/measure of listhesis and bone deformities).
- **Central stenosis, subarticular recess stenosis, and foraminal stenosis** with grade and reference to nerve root impingement.
- **Disc herniation** with size (AP diameter), type if apparent (protrusion, extrusion and sequestered or transligamentous), caudal or cephalad dissection, and neural impingement.*

L4-5: repeat above for this level.

L3-4: repeat above for this level.

Repeat for each individual level. If two or more levels are the same or similar you can combine these levels.

Cord and intradural findings.
Bone, bone marrow and paraspinous soft tissue findings.

**CONCLUSION:** General statement if appropriate including comments on the diagnostic quality or adequacy concerning the clinical question:

1. Primary abnormality accounting for the patient’s symptoms or complaint.
2. Abnormalities which may also contribute to the patient’s symptoms, or which may confound the initial diagnosis.
3. Findings that may directly impact surgery or treatment of the primary abnormality.
4. Comparisons with prior studies (or reports if appropriate).
5. Significant negatives, or incidental findings with management recommendations.

The conclusions should be stated in a bullet point format and the use of full sentences should be avoided. The patient’s symptoms or diagnosis should be addressed and a specific diagnosis should be given when appropriate. A limited or relevant differential diagnosis should be given with recommendations for follow-up testing when appropriate.

* Please see CDI Quality Institute Guideline concerning definitions and diagnostic criteria in the lumbar spine.