CLINICAL DEMONSTRATION CHECKLIST

UPPER EXTREMITY POSTIONING CLASS

Name_____
Instructor_____
Date_____

	Patient Positioning	Film Position Orientation	CR	Sign Off
Digit: (required)				
Digit: (recommended)				
PA Finger	_____	_____	_____	_____
Oblique Finger	_____	_____	_____	_____
Lateral Finger	_____	_____	_____	_____
AP Thumb	_____	_____	_____	_____
Oblique Thumb	_____	_____	_____	_____
Lateral Thumb	_____	_____	_____	_____
Digit: (suggested)				
_____				
Hand: (required)				
PA	_____	_____	_____	_____
Oblique	_____	_____	_____	_____
Lateral	_____	_____	_____	_____
Hand: (suggested)				
Hand: (recommended)				
_____				
Wrist: (required)				
PA	_____	_____	_____	_____
Oblique 45^0	_____	_____	_____	_____
Lateral	_____	_____	_____	_____
Wrist: (recommended)				
PA for Scaphoid	_____	_____	_____	_____

Wrist: (suggested)

Scaphoid (Stecher)	_____	_____	_____	_____
Carpal Canal	_____	_____	_____	_____

_____

Forearm: (required)

AP	_____	_____	_____	_____
Lateral	_____	_____	_____	_____

Forearm: (recommended)

Forearm: (suggested)

_____

Elbow: (required)

AP	_____	_____	_____	_____
Lateral	_____	_____	_____	_____

Elbow: (recommended)

External Oblique	_____	_____	_____	_____
Internal Oblique	_____	_____	_____	_____

Elbow: (suggested)

AP Partial Flexion	_____	_____	_____	_____
Axial Trauma (Coyle)	_____	_____	_____	_____

_____

Humerus: (required)

Humerus: (recommended)

AP	_____	_____	_____	_____
Lateral	_____	_____	_____	_____
Scapular Y	_____	_____	_____	_____

Humerus: (suggested)

AP Neutral	_____	_____	_____	_____
Transthoracic Lateral	_____	_____	_____	_____

_____

Shoulder: (required)

AP Int. Rot.	_____	_____	_____	_____
AP Ext. Rot.	_____	_____	_____	_____

Shoulder: (recommended)

AP Neutral	_____	_____	_____	_____
Transthoracic Lateral	_____	_____	_____	_____
Scapular Y	_____	_____	_____	_____
One Axial view (specify)	_____	_____	_____	_____

Shoulder: (suggested)

Inferosuperior Axial	_____	_____	_____	_____
Superoinferior Axial	_____	_____	_____	_____
Posterior Oblique (Grashey)	_____	_____	_____	_____
Tangential	_____	_____	_____	_____

_____

Scapula: (required)

Scapula: (recommended)

AP	_____	_____	_____	_____
Lateral, Anterior Oblique	_____	_____	_____	_____
Lateral, Posterior Oblique	_____	_____	_____	_____

Scapula: (suggested)

_____

Clavicle : (required)

Clavicle : (recommended)

AP	_____	_____	_____	_____
AP Angle 15-30^0 Cephalad	_____	_____	_____	_____

Clavicle : (suggested)

PA Angle 15-30^0 Caudad	_____	_____	_____	_____

_____

Acromioclavicular Joints: (required)

Acromioclavicular Joints: (recommended)

AP Bilateral With Weights	_____	_____	_____	_____
AP Bilateral Without Weights	_____	_____	_____	_____

Acromioclavicular Joints: (suggested)

_____

REQUIRED = 12 ELECTIVE = 4 TOTAL = 16