Scaphoid Fracture Test

Patient Information	
Name:	Date of Birth:
Referring Physician:	Date of Assessment:
Consent for Evaluation	
I, _____, hereby give consent to undergo the Scaphoid Fracture Test as part of my diagnostic evaluation for wrist pain. I understand the procedures involved and agree to cooperate fully.	
Patient’s Signature:	Date:
Physical Examination	
Anatomical Snuffbox Tenderness:	◯ Yes ◯ No
Scaphoid Tubercle Tenderness:	◯ Yes ◯ No
Ulnar Deviation Pain:	◯ Yes ◯ No
Comments:	
Imaging Tests	
1. X-ray	
Date:	
Findings:	
Observations:	

2. MRI (if indicated)

Date:

Findings:

Observations:

3. CT Scan (if necessary)

Date:

Findings:

Observations:

4. Ultrasound (optional)

Date:

Findings:

Observations:

Diagnosis

Preliminary Diagnosis:

◯ Suspected Scaphoid Fracture ◯ No Fracture Detected

Type of Scaphoid Fracture (if any):

◯ Non-Displaced ◯ Displaced ◯ Acute ◯ Occult

Specific Location:

◯ Proximal Pole ◯ Waist ◯ Distal Pole

Treatment Recommendations

☐ Cast Immobilization

Duration:

☐ Surgical Intervention

Type of Surgery:

☐ Follow-Up MRI / CT

Scheduled Date:

Additional Notes:

Physician's Signature

Name:

Signature:

Date:

Patient Acknowledgement

I acknowledge the receipt of the above diagnosis and understand the recommended treatment plan. I agree to follow up as advised and understand the importance of adhering to the treatment regimen for optimal recovery.

Patient's / Guardian's Signature:

Date:

This template is intended to guide healthcare providers through the systematic evaluation and management of suspected scaphoid fractures, ensuring a comprehensive approach to diagnosis and treatment.