RadiologyAssociates

PAIN MANAGEMENT REQUISITION

Booking Information
Phone: 403-328-1122
Fax: 403-328-1218
1122 Scenic Drive South
Lethbridge AB T1K 7E5
radiologyassociatesinc.com

PATIENT

APPOINTMENT DATE / TIME:

BRING VALID HEALTH CARE CARD & THIS FORM. If you are unable to attend your appointment, please call to cancel or reschedule at least 2 hours prior to your appointment.

NAME: (LAST) (FIRST) (MIDDLE)
ADDRESS: CITY:
POSTAL CODE: PROVINCE:
PHONE #: HOME WORK / CELL

☐ AHC #: ☐ OUT OF PROVINCE
☐ WCB ☐ PATIENT PAY ☐ PRIVATE
AGE: DOB: (MM / DD / YEAR) LMP: (MM / DD / YEAR)
☐ MALE ☐ FEMALE PREGNANT: ☐ YES ☐ NO

REFERRAL

ORDERING PHYSICIAN:
CLINIC NAME:
FAX REPORTS TO #:

SEND COPY TO:
CLINIC NAME:
FAX REPORTS TO #:

HISTORY & PROVISIONAL DIAGNOSIS:

☐ ANTIBIOTICS
☐ ANTICOAGULATION:
Type:
☐ BLEEDING DISORDER
☐ BMI >40 (Send requisition to hospital)
☐ CONTRAST / DYE ALLERGY

☐ DIABETIC
☐ LATEX ALLERGY
☐ LIMITED MOBILITY
☐ PREGNANT
☐ OTHER:
☐ Discretion to modify order as per Radiologist

_____ x **per year** (max 4 times per site per year)

Relevant prior MRI or CT : (LOCATION AND DATE OF EXAM)

PERIPHERAL

ANKLE & FOOT
☐ MTP JOINT ☐ L ☐ R
Site:
☐ ANKLE (TIBIOTALAR) ☐ L ☐ R
☐ PLANTAR FASCIA ☐ L ☐ R
☐ RETROCALCANEAL BURSA ☐ L ☐ R
☐ SUBTALAR JOINT ☐ L ☐ R
☐ TMT JOINT ☐ L ☐ R
Site:
☐ MORTON'S NEUROMA (Alcohol) ☐ L ☐ R
☐ MORTON'S NEUROMA (Steroid only) ☐ L ☐ R

KNEE
☐ BAKER'S CYST ☐ L ☐ R
Previous US required to confirm cyst
☐ KNEE JOINT ☐ L ☐ R
☐ PATELLAR TENDON ☐ L ☐ R
☐ PES ANSERINE ☐ L ☐ R
☐ QUADRICEPS TENDON ☐ L ☐ R

HIP & PELVIS
☐ GREATER TROCHANTERIC BURSA ☐ L ☐ R
☐ HIP JOINT ☐ L ☐ R
☐ ISCHIAL BURSA ☐ L ☐ R
☐ ILIOPSOAS BURSA ☐ L ☐ R
☐ SYMPHYSIS PUBIS

WRIST & HAND
☐ RADIOCARPAL JOINT ☐ L ☐ R
☐ 1ST CMC JOINT ☐ L ☐ R
☐ 1ST EXTENSOR TENDON ☐ L ☐ R
☐ GANGLION CYST ☐ L ☐ R
☐ FLEXOR TENDON ☐ L ☐ R
Site:
☐ MCP JOINT ☐ L ☐ R
Site:
☐ IP JOINT ☐ L ☐ R
Site:

ELBOW
☐ ELBOW JOINT ☐ L ☐ R
☐ LATERAL EPICONDYLE ☐ L ☐ R
☐ MEDIAL EPICONDYLE ☐ L ☐ R
☐ OLECRANON BURSA ☐ L ☐ R

SHOULDER
☐ AC JOINT ☐ L ☐ R
☐ BICEPS TENDON LONG HEAD ☐ L ☐ R
☐ GLENOHUMERAL JOINT ☐ L ☐ R
☐ HYDRODILATATION ☐ L ☐ R
☐ SUBACROMIAL BURSA ☐ L ☐ R
Must have previous U/S of shoulder within the last 2 years. If full thickness tear present, Gleno Joint would be preferable.

MSK REGENERATIVE THERAPIES
Site:
☐ PERCUTANEOUS FENESTRATION / DRY NEEDLING
☐ CALCIFIC TENDONITIS BARBOTAGE
☐ PRP* (PLATELET-RICH PLASMA)
*A charge will apply, call for more information.

NERVE BLOCKS
☐ MEDIAN - CARPAL TUNNEL ☐ L ☐ R
☐ ILIOINGUINAL / HYPOGASTRIC ☐ L ☐ R
☐ POSTERIOR TIBIAL ☐ L ☐ R
☐ LATERAL FEMORAL CUTANEOUS ☐ L ☐ R
☐ GREATER OCCIPITAL ☐ L ☐ R
☐ ULNAR - CUBITAL TUNNEL ☐ L ☐ R
☐ SUPRASCAPULAR ☐ L ☐ R
☐ OTHER: ☐ L ☐ R

*HYALURONIC ACID SUPPLEMENTS
☐ SPORTVIS Site:
☐ CINGAL Site:
☐ MONOVISC Site:
*Non-insured - call for pricing

SPINAL

☐ **FACET JOINT INJECTION**
☐ LUMBAR ☐ CERVICAL
☐ THORACIC
Level:
☐ L ☐ R

☐ **PARS INTERARTICULARIS**
Level:
☐ L ☐ R

☐ **SACROILIAC JOINT**
☐ L ☐ R

☐ **TRANSFORAMINAL EPIDURAL / SPINAL NERVE ROOT BLOCK**
☐ DIAGNOSTIC ONLY - LOCAL ANAESTHETIC
☐ DIAGNOSTIC & THERAPEUTIC
Level / Specific Nerve:
☐ L ☐ R

☐ **INTERLAMINAR EPIDURAL**
Level:

☐ **POSTERIOR SUPERIOR ILIAC SPINE**

☐ **LUMBAR SYMPATHETIC BLOCK**
Level:
☐ L ☐ R

☐ **TEMPOROMANDIBULAR JOINT**
☐ L ☐ R

☐ COCCYX

* Medial Branch Blocks refer to Calgary.
* No Cervical Epidurals refer to Calgary

BOTOX

☐ **CHRONIC MIGRAINE**
PATIENTS BEING REFERRED MUST MEET THESE CRITERIA:

☐ Secondary causes have been ruled out.
☐ >15 headache days/month with >8 being migrainous.
☐ Headaches typically last >4 hours at a time.

☐ **OTHER BOTOX** (a charge may apply)
Site: