RadiologyAssociates

PAIN MANAGEMENT REQUISITION

Booking Information

Phone: 403-328-1122
Fax: 403-328-1218

1122 Scenic Drive South
Lethbridge AB T1K 7E5

www.lethbridgeradiology.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:

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

- ☐ 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

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

PERIPHERAL

MSK REGENERATIVE THERAPIES

Site:______________

- ☐ PERCUTANEOUS FENESTRATION / DRY NEEDLING
- ☐ PROLOTHERAPY
- ☐ CALCIFIC TENDONITIS BARBOTAGE
- ☐ PRP* (PLATELET-RICH PLASMA)

*A charge will apply, call for more information.

TRIGGER POINT / OTHER SITE

Site:______________

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

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:______________

KNEE

- ☐ BAKER'S CYST ☐ L ☐ R
- ☐ KNEE JOINT ☐ L ☐ R
- ☐ PATELLAR TENDON ☐ L ☐ R
- ☐ QUADRICEPS TENDON ☐ L ☐ R

HIP & PELVIS

- ☐ GREATER TROCHANTERIC BURSA ☐ L ☐ R
- ☐ HIP JOINT ☐ L ☐ R
- ☐ ISCHIAL 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

SPINAL

☐ FACET JOINT INJECTION

- ☐ LUMBAR
- ☐ THORACIC
- ☐ CERVICAL

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

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:______________