MAYFAIR DIAGNOSTICS

IMAGE-GUIDED PAIN THERAPY REQUISITION

ALL APPOINTMENTS:
Tel: 403.777.3122
Fax: 403.777.3001
paintherapy@radiology.ca

PATIENT INFORMATION

PLACE PATIENT LABEL HERE

Date of Request: D/ M/ Y/

Name: ☐ Female ☐ Male

Address:

City: Province: Postal Code:

Home Phone:

Other Phone:

Email Address:

Date of Birth: D/ M/ Y/

AHC or WCB #:

Appt. Date: D/ M/ Y/ Time:

HISTORY AND PRESUMPTIVE DIAGNOSIS

Please provide all relevant information.

FOR REFERRER

Number of repeats/year: ____
(Limit 4 injections per site per year)

Relevant previous imaging:

- ☐ X-ray Date:
- ☐ Ultrasound Date:
- ☐ MRI Date:
- ☐ Other: Date:

THERAPY SITE REQUESTED (Additional imaging will be coordinated, if appropriate.)

Musculoskeletal Procedures

Shoulder

Subacromial Bursa	☐ R	☐ L
Glenohumeral Joint	☐ R	☐ L
AC Joint	☐ R	☐ L
Biceps Tendon (long head)	☐ R	☐ L
Tendon Calcification	☐ R	☐ L

Elbow

Elbow Joint	☐ R	☐ L
Lateral Epicondyle	☐ R	☐ L
Medial Epicondyle	☐ R	☐ L
Olecranon Bursa	☐ R	☐ L

Wrist & Hand

Radiocarpal Joint	☐ R	☐ L
1st CMC Joint	☐ R	☐ L
Carpal Tunnel	☐ R	☐ L
Extensor/DeQuervain's (level)	☐ R	☐ L
Flexor/Trigger (level)	☐ R	☐ L
Ganglion Cyst	☐ R	☐ L
Other Joint:	☐ R	☐ L

Knee

Knee Joint	☐ R	☐ L
Baker's Cyst	☐ R	☐ L

Hip & Pelvis

Hip Joint	☐ R	☐ L
Greater Trochanteric Bursa	☐ R	☐ L
Iliopsoas Bursa	☐ R	☐ L
Ischial Bursa	☐ R	☐ L
Symphysis Pubis	☐	

Ankle & Foot

Ankle Joint	☐ R	☐ L
Subtalar Joint	☐ R	☐ L
1st MTP Joint	☐ R	☐ L
Plantar Fascia	☐ R	☐ L
Ganglion Cyst	☐ R	☐ L
Morton's Neuroma	☐ R	☐ L
Other Joint:	☐ R	☐ L

Other

Tenotomy	☐ R	☐ L
Site: (Specify Indication)		
Other:	☐ R	☐ L
Site: (Specify Indication)		

☐ **For Pre-Injection Assessment**
(If checked, we will review prior imaging and suggest appropriate injection therapy.)

Spinal Procedures

☐ **SPECT/CT Bone Scan** (to guide facet injections)

☐ **Facet Injection** OR ☐ **Medial Branch Block** OR ☐ **Radiofrequency Ablation*** (L-Spine)	Cervical	☐ R	☐ L (level)
	Thoracic	☐ R	☐ L (level)
	L1/L2	☐ R	☐ L
	L2/L3	☐ R	☐ L
	L3/L4	☐ R	☐ L
	L4/L5	☐ R	☐ L
	L5/S1	☐ R	☐ L

☐ **SI Joint** ☐ R ☐ L
☐ **Coccyx**

☐ **Selective Nerve Root Block****
(transforaminal/TFESI)

L3	☐ R	☐ L
L4	☐ R	☐ L
L5	☐ R	☐ L
S1	☐ R	☐ L

☐ **Cervical Epidural** (Trans Facet) ☐ R ☐ L (level)

☐ **Epidural Injection**** (interlaminar) ☐ L3/L4 ☐ L4/L5 ☐ L5/S1 ☐ Caudal

☐ **Other:**

* If determined appropriate based on MBB results
** MRI required before injection

INJECTION TYPE

Steroid Injection performed unless otherwise indicated

☐ **Viscosupplementation** (Hyaluronic Acid): (Specify Type)
(Most available on site for purchase)

Fee-for-Service

- ☐ **Prolotherapy:**
- ☐ **PRP** (Platelet Rich Plasma):
- ☐ **Botox:**

PATIENT INFORMATION

Medications

- ☐ Coumadin
- ☐ Plavix
- ☐ Other Blood Thinners:

Allergies

- ☐ Xylocaine
- ☐ Iodinated Contrast
- ☐ Other:

☐ **Diabetic**

REFERRER INFORMATION

Name:

Copy to:

Phone: Fax:

Address:

Practitioner's ID/Stamp:

Signature:

See reverse for patient instructions and location map.

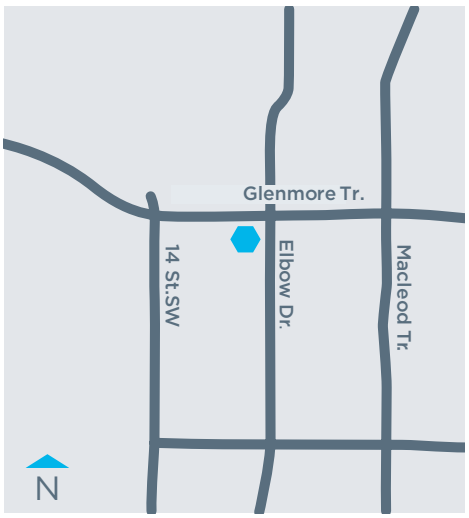
A booking coordinator will contact your patient to schedule their appointment. Pain therapy services are covered by Alberta Health Care (unless indicated).

- **Please bring this requisition form** to your appointment.
- **Arrive 15 minutes prior to your appointment**. If you are late, your examination may have to be postponed to a later date.
- Allow 20–30 minutes for your appointment and wear comfortable clothing.
- There are no food or drink restrictions. If you are an insulin dependent **diabetic**, please ensure you have some juice and/or a small snack after taking your insulin.
- Continue taking all of your current medications. If you are on **anticoagulant drugs** (Plavix, Coumadin, Warfarin) you may need to have your INR checked and may need to stop your medication prior to the procedure. Our Booking Coordinator will discuss this with you.
- **ALL INTRA-ARTICULAR MEDICATIONS (CORTICOSTEROID AND LONG-ACTING LOCAL ANAESTHETIC) ARE PROVIDED TO YOU AT YOUR APPOINTMENT.**

  IF YOU ARE PRESCRIBED VISCOSUPPLEMENTATION (E.G. HYALURONIC ACID, SYNVISC, ORTHOVISC, ETC.), WE OFFER SOME AT DIRECT COST AT OUR FACILITY. OTHERWISE PLEASE BRING THIS MEDICATION WITH YOU TO YOUR APPOINTMENT.
- If possible, please **have someone accompany you on the day of your test.** In case you have any discomfort, it may be more convenient to have someone else drive you home. Selective Nerve Root Block, Epidural Injection, as well as Radiofrequency Ablation patients must have a driver.
- X-rays may be taken prior to the injection.
- Patients are allowed to leave after their exam with no recuperation time required. **Exception:** Selective Nerve Root Block, Epidural Injection, as well as Radiofrequency Ablation patients will require an additional 15–30 minutes recovery after the procedure.
- Please do not hesitate to contact us if you have any questions about these procedures.
- Please do not bring children who require supervision to your appointment.

LOCATION

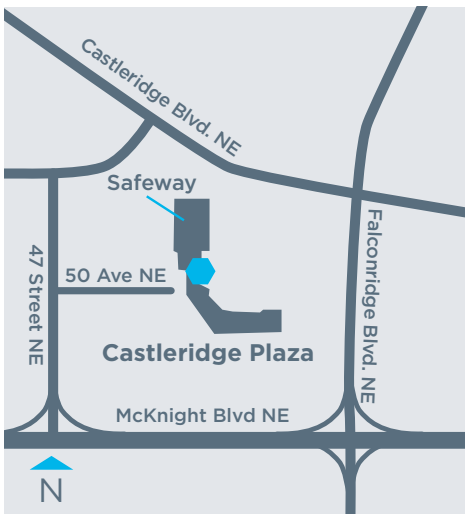
Mayfair Place



132 Mayfair Place, 6707 Elbow Dr. SW

Free Parking (Some reserved Mayfair spots)

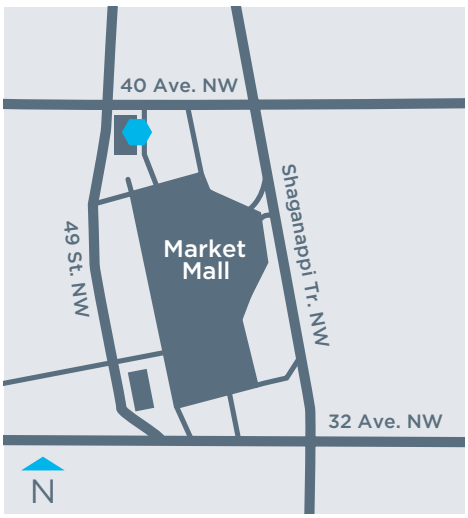
Castleridge Plaza



20, 55 Castleridge Blvd. NE

Free Parking

Market Mall



Market Mall, 333, 4935 40 Ave. NW

Free Parking

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ORDER FORM

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403.777.3122

Attention! You are almost out of Pain Therapy Requisition forms.

TO REPLENISH YOUR SUPPLY OF PAIN THERAPY REQUISITION FORMS:

Call us at 403.777.3122

E-mail your request to requisitions@radiology.ca

Fax this form to 403.777.3001

Print requisitions directly from radiology.ca/requisition-forms

EMR upload assistance available. Please contact us at the above phone number or email address.

Clinic: _____

Address: _____

Phone: _____

Email: _____

Number of requisition pads required: _____

Thank you for your referrals.

☐ **Check this box if you would like to be emailed information regarding Continuing Health Education (CHE) events and company news.**