MAYFAIR® DIAGNOSTICS

PAIN MANAGEMENT REQUISITION

ALL APPOINTMENTS:
Tel: 403.777.3000
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: ______

Date of Birth: D/ M/ Y/

AHC or WCB #: ______

Appt. Date: D/ M/ Y/ Time: ______ am pm

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: ______

PROCEDURE 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.)

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: ______ (Specify Type)
(Most available onsite for purchase)

Fee-for-Service
Biologics:
- **PRP** (Platelet Rich Plasma): ______
- **APS** (Autologous Protein Solution/nSTRIDE®): ______

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: ______

To book an appointment 403.777.3000
paintherapy@radiology.ca

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

- **Please bring** your health insurance card, photo identification, and 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 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, and 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, and radiofrequency ablation patients will require an additional 15–30 minutes recovery after the procedure.
- Please contact us if you have any questions about these procedures.
- Please do not bring children who require supervision to your appointment.