

VERTEBRAL AUGMENTATION REQUEST FORM Appt Date/Time _____

PLEASE FAX A COPY OF THE REQUEST TO CENTRAL ALBERTA MEDICAL IMAGING SERVICES LTD. 403-343-6159

Patient Information

Name _____ DOB (D/M/Y) _____ M F
 Address _____ A.H.C.# _____
 City _____ WCB Claim # _____
 Province _____ Postal Code _____ Date of Injury (D/M/Y) _____
 Phone Home _____ Alt _____

Diagnosis Vertebral Compression Fracture

Level
 T6 T7 T8 T9 T10 T11 T12 L1 L2 L3 L4 L5

Fracture Type

Wedge Bi-concave Crush

Probable Age of Fracture

1-4 Weeks 5-8 Weeks 2-6 Weeks 6 months & more

Possible Cause of Fracture


Primary Osteoporosis Secondary Osteoporosis
 Osteolytic Lesion Trauma

Neurologic Deficit

No Yes
 → Numbness
 → Muscular Weakness

Available Imaging

X-ray Only CT Scan
 MRI Bone Scan

 *** Please attach all available reports to expedite the referral process.**
*** Please include requests for MRI and Nuclear Medicine with this request.**

Referring Physician

Stat Report

Name _____
 Address _____
 Phone _____ Fax _____

Actual Patient State Acute pain Chronic pain

Level of pain
 1 2 3 4 5 6 7 8 9 10

Patient on bed rest
 Patient taking analgesics
 Patient taking narcotics

Physical Exam

Tenderness at site (focal pain)
 Generalized back pain
 Possible neurological compromise
 (spinal cord compression)

Allergies

Iodine allergy
 Other _____

Additional Data

Patient on anticoagulants
 Patient on antiplatelet agent
 Patient respiratory compromised

Contra-indications

Active infection

Bone Densitometry (DEXA)

No
 Yes → Score/result _____
 Patient on antiresorptive therapy

PRAC ID _____
 Signature _____
 CC _____
 _____ Fax _____