Central Alberta
Medical Imaging Services

P: 403-755-8060 or 403-755-8068 | F: 403-309-0093 | www.camiscare.ca
info@camiscare.ca

SPINAL INTERVENTION REQUEST FORM

Appt Date/Time _____

PLEASE FAX A COPY OF THE REQUEST TO CENTRAL ALBERTA MEDICAL IMAGING SERVICES LTD. 403-309-0093

Patient Information

Name _____ M ☐ F ☐ Other ☐

Address _____ DOB (D/M/Y) _____

City _____ A.H.C.# _____

Province _____ Postal Code _____ WCB Claim # _____

Phone Home _____ Alt _____ Date of Injury (D/M/Y) _____

Clinical Information (Required) _____

_____

_____

Spinal Procedures: Pain Management

☐ **Cervical Facet**

C2/3 Right ☐ Left ☐
C3/4 Right ☐ Left ☐
C4/5 Right ☐ Left ☐
C5/6 Right ☐ Left ☐
C6/7 Right ☐ Left ☐
C7/T1 Right ☐ Left ☐

☐ **Thoracic Facet**

Right ☐ Left ☐

level(s) required:
_____
_____
_____

☐ **Lumbar Facet Injection**

L1/2 Right ☐ Left ☐
L2/3 Right ☐ Left ☐
L3/4 Right ☐ Left ☐
L4/5 Right ☐ Left ☐
L5/S1 Right ☐ Left ☐

☐ **Medial Branch Block**

(T12, L1 MBB)
(L1, L2 MBB)
(L2, L3 MBB)
(L3, L4 MBB)
(L4MBB, L5 dorsal ramus)

☐ **Pars Interarticularis Block (Spondylolysis)**

Indicate Level Required _____ Right ☐ Left ☐

☐ **SI Joint** Right ☐ Left ☐

☐ **Psoas Muscle** Right ☐ Left ☐

☐ **Greater Occipital NB** Right ☐ Left ☐

☐ **Coccyx** _____

☐ **Other** _____

☐ **Spect/CT Bone Scan**
(To guide facet injections)

☐ **Transforaminal Epidural**
(Therapeutic)

L1/2 Right ☐ Left ☐
L2/3 Right ☐ Left ☐
L3/4 Right ☐ Left ☐
L4/5 Right ☐ Left ☐
L5/S1 Right ☐ Left ☐

☐ **Translaminar Epidural**
(Therapeutic) (Bilateral Radiculopathy)
Level _____

☐ **Select Nerve Root Block**
(Diagnostic)

L3 Right ☐ Left ☐
L4 Right ☐ Left ☐
L5 Right ☐ Left ☐
S1 Right ☐ Left ☐

Patients require pain diary:
Yes ☐ No ☐

CT or MRI reference imaging required for epidural/nerve block injections

Referring Physician

Stat Report ☐

Name _____

Address _____

_____

Phone _____ Fax _____

PRAC ID _____

Signature _____

CC _____

_____ Fax _____