Central Alberta
Medical Imaging Services

P: 403-343-6172 | F: 403-343-6159 | www.camiscare.ca
info@camiscare.ca

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 _____ 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) _____

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.**

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

_____

Referring Physician

Stat Report ☐

Name _____

Address _____

_____

Phone _____ Fax _____

PRAC ID _____

Signature _____

CC _____

_____ Fax _____