

MSK IMAGING & 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)

Diagnostic Imaging

MSK Ultrasound (to assess tendons, ligaments and muscles)

| | | | |
|-----------------|---|--------------------------|---|
| Shoulder | <input type="checkbox"/> R <input type="checkbox"/> L | Quadriceps | <input type="checkbox"/> R <input type="checkbox"/> L |
| Elbow | <input type="checkbox"/> R <input type="checkbox"/> L | Greater Trochanter Bursa | <input type="checkbox"/> R <input type="checkbox"/> L |
| Wrist | <input type="checkbox"/> R <input type="checkbox"/> L | Iliopsoas Bursa | <input type="checkbox"/> R <input type="checkbox"/> L |
| Hand | <input type="checkbox"/> R <input type="checkbox"/> L | Ankle | <input type="checkbox"/> R <input type="checkbox"/> L |
| Achilles Tendon | <input type="checkbox"/> R <input type="checkbox"/> L | Morton's Neuroma | <input type="checkbox"/> R <input type="checkbox"/> L |
| Plantar Fascia | <input type="checkbox"/> R <input type="checkbox"/> L | Knee | <input type="checkbox"/> R <input type="checkbox"/> L |
| Other _____ | | | |

Soft Tissue Ultrasound (to assess soft tissue mass)

Lipoma Area _____
 Ganglion Area _____
 Ganglion Aspiration and Injection
 Other: _____

If pathology is found in the area of interest you may expedite the patient's treatment. By checking the box below the patient will be booked for a therapeutic injection if appropriate.

Please proceed with appropriate therapeutic injection

Interventional Procedures *some interventional procedures require prior imaging. This will be arranged by our office*

Prolotherapy (series of 3 treatments)

Achilles Tendon R L
 Lateral Elbow R L
 Medial Elbow R L
 Patellar Tendon R L

Special Procedures

Calcific Tendinopathy Barbatoge
 _____ R L

Ganglion Aspiration and Injection
 Area _____ R L

PRP (Uninsured Services)

Patient is interested in PRP
 Knee Joint R L
 Lateral Elbow R L
 Medial Elbow R L
 Repeat

Steroid Injections

Shoulder Joint R L
 Shoulder Bursa R L
 AC Joint R L
 Biceps Tendon Sheath R L
 Elbow Joint R L
 Wrist Joint R L
 Carpal Tunnel R L
 CMC Joint R L
 Hand R L
 Digit _____
 MCP DIP PIP
 Trigger Finger R L
 DeQuervain's R L
 Foot R L
 Digit _____
 MTP DIP PIP

Plantar Fascia R L
 Ankle Joint R L
 Talonavicular Joint R L
 Subtalar Joint R L
 Morton's Neuroma R L
 Posterior Tibialis R L
 Peroneal Tendons R L
 Knee Joint R L
 Pes Anserine Bursa R L
 Hip Joint R L
 Greater Trochanter Bursa R L
 Ischial Tuberosity R L
 Psoas Muscle R L
 Iliopsoas Bursa R L
 Other: _____

Referring Physician

Name _____
 Address _____
 Phone _____ Fax _____

Stat Report

PRAC ID _____
 Signature _____
 CC _____ Fax _____