

PATIENT INFORMATION (AFFIX LABEL IF AVAILABLE)

Check if Applicable: URGENT

Full Name (Birth): _____

Preferred Full Name (If Different from Birth): _____

Address: _____

City: _____ Prov.: _____ Postal Code: _____

Cell Phone: _____ Alt. Phone: _____

Date of Birth: _____

Health Card #: _____ Version: _____

Gender: _____ Preferred Gender (If Different from Birth): _____

Height (cm): _____ Weight (kg): _____

Reason for Referral:

THERAPEUTIC JOINT/BURSA INJECTION/ARTHOGRAM

Shoulder

- R L**
 Glenohumeral Joint Repeat q _____ months
 Acromioclavicular Joint/Subacromial Bursa Repeat q _____ months

Wrist

- R L**
 Radiocarpal Joint Repeat q _____ months

Hand

- R L**
 Carpometacarpal Joint Finger: 1 2 3 4 5 Repeat q _____ months
 Metacarpophalangeal Joint Finger: 1 2 3 4 5 Repeat q _____ months

Pelvis

- R L**
 Sacroiliac Joint Repeat q _____ months
 Femoroacetabular Joint Repeat q _____ months
 Gr. Trochanteric Bursa Repeat q _____ months
 Iliolumbar Ligament Repeat q _____ months

Knee

- R L**
 Knee Repeat q _____ months

Ankle

- R L**
 Subtalar Joint Repeat q _____ months
 Tibiotalar Joint Repeat q _____ months

Foot

- R L**
 Tarsometatarsal Joint Repeat q _____ months
Indicate which tarsal bone: _____

FOR OTHER SITES/PROCEDURES, PLEASE CONTACT THE CLINIC DIRECTLY:

- R L**
 _____ Repeat q _____ months

PARAVERTEBRAL NERVE BLOCK

- R L**
 Cervical Levels _____ Repeat q _____ months
 Thoracic Levels _____ Repeat q _____ months
 Lumbar Levels _____ Repeat q _____ months

EPIDURAL

- R L**
 Cervical Repeat q _____ months
 Thoracic Repeat q _____ months
 Lumbar Repeat q _____ months

REFERRING HEALTHCARE PROVIDER (STAMP LABEL IF AVAILABLE)

Referring Provider: _____
(Print Name)

(Signature)

Billing Provider #: _____

CPSO #: _____

Tel #: _____

Fax #: _____

Date: _____

Copy To: _____

Report Delivery Preference: Fax HRM Other: _____

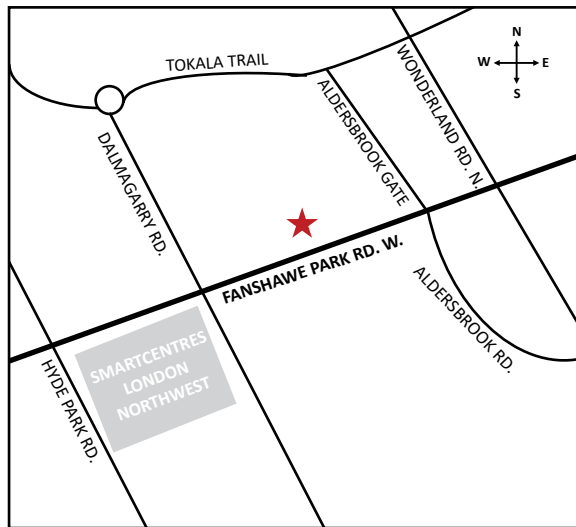
All our services require a scheduled appointment.
Please provide 24 hours' notice if you need to reschedule your appointment to avoid a no-show fee.
For the latest clinic information, or to chat live and book your appointment online, please visit **MyHealthCentre.ca**.

FLUOROSCOPY PRE-PROCEDURE INSTRUCTIONS

- Please arrange for a person to bring you to your appointment and take you home post-procedure.
- Please arrive 15 minutes before your scheduled appointment. The procedure will take approximately 30 minutes.
- Please bring your valid health card, any relevant WSIB information (claim number, date of injury and site of injury), and all your medications with you on the day of your appointment.
- You may eat and drink, but should restrict your intake to a light meal before the procedure.
- If you are taking oral anticoagulant or antiplatelet medication (blood thinners) such as ASA (Aspirin®), Apixaban (Eliquis®), Rivaroxaban (Xarelto®), Edoxaban (Lixiana®), Dabigatran (Pradaxa®), Clopidogrel (Plavix®), Ticagrelor (Brilinta®), or Dipyridamole + ASA (Aggrenox®), you must consult your family doctor about when to stop this medication before your procedure, unless your pain doctor tells you not to, as most procedures require this.
- If you are taking injectable anticoagulant medications (blood thinners) such as heparin, dalteparin (Fragmin®), enoxaparin (Lovenox®), tinzaparin (Innohep®), or fondaparinux (Arixtra®), please consult your pain specialist for direction on when to stop this medication prior to your procedure.
- Take other prescribed medication in the morning with some water.
- If you have diabetes, you will need to remove any blood sugar sensors/transmitters/ receivers or insulin pumps because these items should not be exposed to radiation.

Please visit myhealthcentre.ca/test-prep for more information on:

- Epidural Steroid Injection
- Facet Joint Injection
- Sacroiliac Joint Injection
- Post-procedure instructions



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SERVICES: Bone Mineral Density, Mammography & OBSP,
Nuclear Cardiology, Pain Injection, Prenatal Screening,
Ultrasound, Vascular Ultrasound, X-ray (Walk-in Service)



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