

**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.

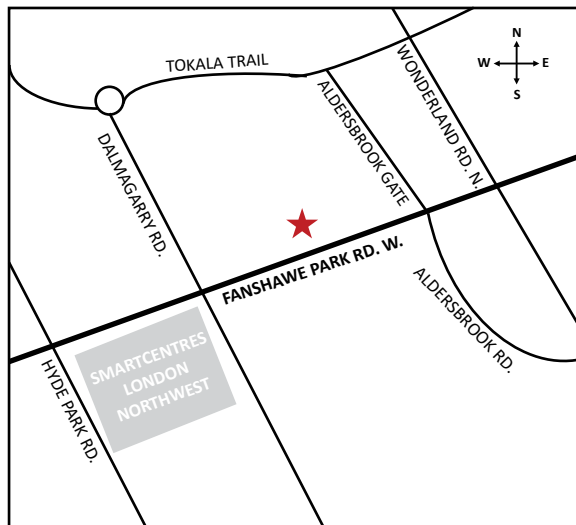
For the latest clinic information, or to chat live and book your appointment online, please visit [MyHealthCentre.ca/Locations](https://www.myhealthcentre.ca/locations)

## 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](https://www.myhealthcentre.ca/test-prep) for more information on:

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



North London Medical Centre  
1055 Fanshawe Park Road West, Suite 301  
London, ON N6G 5B4

Tel: 519-439-5555 | Fax: 519-266-2206  
E: [london\\_fanshawe@myhealthcentre.ca](mailto:london_fanshawe@myhealthcentre.ca)

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



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