



BGSA RADIOLOGY

PAIN MANAGEMENT

AN ESSENTIAL PART OF YOUR HEALTHCARE TEAM

1854 SOUTHVIEW DRIVE, MEDICINE HAT

BOOKING LINE: 403 527 7334 EXT 142

BOOKING FAX: 403 527 9148

PATIENT INFORMATION

NAME: _____

DOB _____

ADDRESS _____

CITY/PROVINCE _____

PHONE _____

WORK PH _____

AHC# _____

WCB# _____

APPOINTMENT DATE: _____

TIME _____

PATIENT DETAILS

MEDICATIONS:

ANTICOAGULATION Y N TYPE _____

ALLERGIES

LOCAL ANAESTHETIC Y N X-RAY CONTRAST Y N

PATIENT DETAILS

PREGNANT Y N LMP _____

RELEVANT IMAGES & RESULTS _____ ATTACHED _____

PREVIOUS PM injections Y N

When _____ Where _____

RELEVANT HISTORY/ SPECIAL INSTRUCTIONS

THERAPY SITE REQUESTED

TRANSPORTATION

IF YOU ARE HAVING A PROCEDURE INVOLVING THE, NECK or AN EPIDURAL, WE ASK THAT YOU ARRANGE TRANSPORTATION AFTER THE PROCEDURE IS COMPLETE

SYNVISC OR DUROLANE MUST BE SUPPLIED BY THE PATIENT

MEDIAL BRANCH BLOCK

CERVICAL R L LEVEL _____

THORACIC R L LEVEL _____

LUMBAR R L LEVEL _____

INTERLAMINAR EPIDURAL LEVEL _____

PREVIOUS MRI OF AREA IS REQUIRED PRIOR TO BOOKING

TRANSFORAMINAL EPIDURAL LEVEL _____

OTHER AREA _____

Trigger points _____

RADIOLOGIST APPROVED _____

PREVIOUS MRI REQUIRED _____

MRI REVIEWED _____

SPECIFIC JOINT OR AREA:

SHOULDER

SUBACROMIAL BURSA R L

GLENOHUMERAL JOINT R L

AC JOINT R L

BICEPS TENDON (LONG HEAD) R L

ELBOW JOINT R L

LATERAL EPICONDYLE R L

MEDIAL EPICONDYLE R L

OLECRANON BURSA R L

WRIST/HAND

RADIOCARPAL JOINT R L

1ST CMC JOINT R L

CARPAL TUNNEL R L

TRIGGER FINGER R L

OTHER _____ R L

KNEE JOINT R L

BAKER'S CYST R L

HIP & PELVIS

HIP JOINT R L

SI JOINT R L

GREATER TROCHANTERIC BURSA R L

ANKLE/FOOT

TIBIOTALAR JOINT R L

SUBTALAR JOINT R L

TALONAVICULAR JOINT R L

CALCANEOCUBOID JOINT R L

1ST MTP R L

RETROCALCANEAL BURSA R L

PLANTAR FASCIA R L

REFERRING PHYSICIAN _____

COPIES TO _____

REPEATS FOR PROCEDURE (S) YES NO

NUMBER OF TIMES PER YEAR _____