BGSA RADIOLOGY

PAIN MANAGEMENT

AN ESSENTIAL PART OF YOUR HEALTHCARE TEAM

1854 SOUTHVIEW DRIVE, MEDICINE HAT
BOOKING Ph: 403-527-7334 EXT 142
BOOKING Fax: 403-527-9148

PATIENT INFORMATION

NAME: _____

PHN: _____ DOB: _____

ADDRESS: _____

CITY/PROVINCE: _____

PH #: _____ WORK #: _____

WCB#: _____

RELEVANT HISTORY/SPECIAL INSTRUCTIONS

APPOINTMENT DETAILS

DATE/TIME: _____

PATIENT DETAILS

MEDICATIONS:

ANTICOAGULATION: Y ☐ N ☐ TYPE: _____

OTHER: _____

ALLERGIES

LOCAL ANAESTISTIC: Y ☐ N ☐ X-RAY CONTRAST: Y ☐ N ☐

OTHER: _____

PREGNANT: Y ☐ N ☐ LMP: _____

PREVIOUS PM INJECTIONS: Y ☐ N ☐

WHEN: _____ WHERE: _____

PREVIOUS RELEVANT IMAGING: _____

THERAPY SITE REQUESTED

TRANSPORTATION

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

MEDIAL BRANCH BLOCK

CERVICAL R ☐ L ☐ LEVEL _____

THORACIC R ☐ L ☐ LEVEL _____

LUMBAR R ☐ L ☐ LEVEL _____

INTERLAMINAR EPIDURAL LEVEL _____

TRANSFORAMINAL EPIDURAL SIDE R ☐ L ☐ LEVEL _____

OTHER AREA Level _____

TRIGGER POINTS _____

REPEATS FOR PROCEDURE (S) YES ☐ NO ☐
NUMBER PER YEAR ☐ max 4

REFERRING PHYSICIAN: _____

PRAC ID: _____

SIGNATURE: _____

or Physician's Stamp with Prac ID

COPIES TO: _____

SYNVISC OR DUROLANE MUST BE SUPPLIED BY THE PATIENT

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 ☐

SAVE PRINT RESET

MAY2024