PAIN MANAGEMENT REQUISITION

Peace Diagnostic Imaging ltd.

Junction Point Bldg 5
Suite #108 9815-97 St
Grande Prairie, Alberta T8V 8B9
Telephone : (780) 532-5648 FAX: (780) 513-2074

Patient Information		Referring Physician	
Name:		Name:	
Address:		Address:	
City:		Phone:	Fax:
Province:	Postal Code:	Provider ID:	Department ID:
Phone:		LOCUM: YES	
Gender: M F Other		NAME OR PROVIDER # REQUIRED IF YES TO LOCUM	
Date of Birth:		NAME:	
AHC/ULI:		PROVIDER ID:	

CLINICAL INFORMATION (REQUIRED)

MEDICAL HISTORY

Diabetic ☐ Lidocaine Allergy ☐ Anticoagulation ☐ Specify: _____

X-Ray Contrast Allergy ☐ Latex Allergy ☐ Aspirin ☐

CORTICOSTEROID INJECTION SITE

SHOULDER	L	R
Subacromial Bursa	☐	☐
Glenohumeral Joint	☐	☐
AC Joint	☐	☐
Biceps Tendon Sheath	☐	☐

ELBOW	L	R
Elbow Joint	☐	☐
Lateral Epicondyle	☐	☐
Medial Epicondyle	☐	☐
Olecranon Bursa	☐	☐
Cubital Tunnel	☐	☐

WRIST & HAND	L	R
Radiocarpal Joint	☐	☐
1st CMC Joint	☐	☐
Carpal Tunnel	☐	☐
DeQuervain's	☐	☐
Flexor/Trigger	☐	☐
Ganglion Cyst	☐	☐
Digit _____	☐	☐

IP ☐
MCP ☐
DIP ☐
PIP ☐

HIP & PELVIS	L	R
Hip Joint	☐	☐
SI Joint	☐	☐
Greater Trochanter Bursa	☐	☐

FOOT & ANKLE	L	R
Ankle Joint	☐	☐
Subtalar Joint	☐	☐
Ganglion Cyst	☐	☐
Morton's Neuroma	☐	☐
Digit _____	☐	☐

IP ☐
MTP ☐
DIP ☐
PIP ☐

Other: _____

KNEE	L	R
Knee Joint	☐	☐
Baker's Cyst	☐	☐

Other: _____

LUMBAR FACETS

FACETS ☐
MEDIAL BRANCH BLOCK ☐

	L	R
L1/L2	☐	☐
L2/L3	☐	☐
L3/L4	☐	☐
L4/L5	☐	☐
L5/S1	☐	☐

LUMBAR RADICULOPATHY

TRANSFORAMINAL EPIDURAL		SNRB		SIDE	
Therapeutic		Diagnostic		L	R
L1/L2	☐	L3	☐	☐	☐
L2/L3	☐	L4	☐	☐	☐
L3/L4	☐	L5	☐	☐	☐
L4/L5	☐	S1	☐	☐	☐
L5/S1	☐			☐	☐

TRANSLAMINAR EPIDURAL
Therapeutic
Bilateral Radiculopathy
Level

OTHER (Specify):

RAD/TECH NOTES:

PRIOR IMAGING: CT ☐ DATE:_____ MRI ☐ DATE: _____

CT or MRI Imaging is required prior to epidural and nerve block injections.