REQUISITION

PAIN Management Clinic

PEACE DIAGNOSTIC IMAGING
#108, 9815 97 Street
Grande Prairie, AB T8V 8B9
PHONE: 780.532.5648
FAX: 780.513.2074

ORDER DATE: _____

PATIENT INFORMATION

Name _____
Address _____
City _____ Province _____
Postal Code _____ Phone _____
Date of Birth _____
AHC/ULI _____

REFERRING PHYSICIAN

Name _____
Address _____
Phone _____
Provider ID _____
Locum ☐ Yes — Name or provider # required
Name / Provider ID _____

CLINICAL INFORMATION (REQUIRED)

MEDICAL HISTORY

☐ Diabetic ☐ Lidocaine Allergy ☐ Anticoagulation ☐ X-Ray Contrast Allergy ☐ Latex Allergy ☐ Aspirin

STANDING ORDER

Number per year (4 max) _____ **MD Initials** _____

THERAPY OPTIONS

***PDI will use steroid unless otherwise indicated** ☐ Durolane (Available at PDI)

PERIPHERAL PROCEDURES

SHOULDER	L	R
☐ Shoulder (Not Specified)	☐	☐
☐ Glenohumeral Joint	☐	☐
☐ Subacromial Bursa	☐	☐
☐ AC Joint	☐	☐
☐ Biceps Tendon Sheath	☐	☐
☐ Calcific Tendonosis Barbatoge	☐	☐

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

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

HIP AND PELVIS	L	R
☐ Hip Joint	☐	☐
☐ Greater Trochanter Bursa	☐	☐
☐ Ischial Bursa	☐	☐
☐ Piriformis Syndrome	☐	☐
☐ Symphysis Pubis	☐	☐
☐ SI Joint	☐	☐
☐ Coccyx	☐	☐

FOOT AND ANKLE	L	R
☐ Ankle Joint	☐	☐
☐ Subtalar Joint	☐	☐
☐ 1st MTP Joint	☐	☐
☐ Plantar Fascia	☐	☐
☐ Ganglion Cyst	☐	☐
☐ Morton's Neuroma	☐	☐

KNEE	L	R
☐ Knee Joint	☐	☐
☐ Baker's Cyst	☐	☐
☐ Pes Anserine Bursa	☐	☐

OTHER _____
Joint/Tendon/Bursa

SPINE INTERVENTION

LUMBAR

☐ **Facets**
☐ **Medial Branch Block**
☐ **Epidural** ☐ **SNRB**

	L	R	
L1/2	☐	☐	L1
L2/3	☐	☐	L2
L3/4	☐	☐	L3
L4/5	☐	☐	L4
L5/S1	☐	☐	L5
	☐	☐	S1

THORACIC

☐ **Facets**
☐ **Medial Branch Block**

	L	R
T1/2	☐	☐
T2/3	☐	☐
T3/4	☐	☐
T4/5	☐	☐
T5/6	☐	☐
T6/7	☐	☐
T7/8	☐	☐
T8/9	☐	☐
T9/10	☐	☐
T10/11	☐	☐
T11/12	☐	☐

CERVICAL

☐ **Facets**
☐ **Medial Branch Block**
☐ **Transfacet Epidural**

	L	R
C2/3	☐	☐
C3/4	☐	☐
C4/5	☐	☐
C5/6	☐	☐
C6/7	☐	☐
C7/T1	☐	☐

HEADACHE THERAPY

☐ Greater Occipital Nerve
☐ Lesser Occiptal Nerve
☐ TMJ's

INTRALAMINAR EPIDURAL

Level

☐ **Prior imaging (CT/MRI)**
Date _____

☐ **Pre-assessment x-rays**

☐ **Radiologist to assess and treat**