

Central Booking
780-669-2222

Toll Free
1-866-771-9446

Fax
780-930-1593

Toll Free Fax
1-855-930-1593

To cancel or rebook your appointment, please call Central Booking: Mon-Fri: 8AM-8PM, Sat-Sun: 9AM-4PM

Name: _____
Address: _____
Phone: _____ Date of Birth: _____ M F
Insurance: _____ W.C.B.() Other: _____

Appointment Details:

Date: _____
Time: _____
Location: _____

1 | **Single injection** **Series injection** Number of injections (up to 4 per year) _____ MD Initials _____

2 Injection Site

Shoulder	
<input type="checkbox"/> Subacromial Bursa	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Glenohumeral Joint	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Acromioclavicular Joint	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Biceps Tendon (long head)	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Barbotage	R <input type="checkbox"/> L <input type="checkbox"/>
Elbow	
<input type="checkbox"/> Elbow Joint	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Lateral Epicondylitis	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Medial Epicondylitis	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Olecranon Bursa	R <input type="checkbox"/> L <input type="checkbox"/>
Wrist/Hand	
<input type="checkbox"/> Radiocarpal Joint	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> 1st CMC Joint	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Trigger Finger	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> De Quervain's Tenosynovitis	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Ganglion Cyst Aspiration	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Carpal Tunnel	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Specify: _____	
Knee	
<input type="checkbox"/> Knee Joint	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Pes Anserine Bursa	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Baker Cyst Aspiration	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Specify: _____	
<input type="checkbox"/> TMJ	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Greater Occipital Nerve	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Other	

Hip/Pelvis	
<input type="checkbox"/> Hip Joint	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> SI Joint	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Greater Trochanteric Bursa	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Iliopsoas Bursa	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Ischial Bursa	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Coccyx	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Piriformis Syndrome	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Ganglion Impar	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Pubic Symphysis	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Sacral Transverse Joint	R <input type="checkbox"/> L <input type="checkbox"/>
Ankle/Foot	
<input type="checkbox"/> Tibiotalar Joint	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Subtalar Joint	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Talonavicular Joint	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Calcaneocuboid Joint	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> 1st MTP Joint	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Retrocalcaneal Bursa	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Plantar Fasciitis	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Morton's Neuroma	R <input type="checkbox"/> L <input type="checkbox"/>
<input type="checkbox"/> Specify: _____	

Steroid injection performed unless otherwise indicated

Viscosupplementation (Hyaluronic Acid): _____

*Can be supplied by Insight (Fees applicable)

Spinal Procedures			
<input type="checkbox"/> Facets	<input type="checkbox"/> Nerve Root Block		
<input type="checkbox"/> Medial Branch Block	<input type="checkbox"/> Sympathetic Block		
<input type="checkbox"/> Radiofrequency Ablation	<input type="checkbox"/> Synovial Cyst Rupture		
Cervical			
<input type="checkbox"/> C2/C3	<input type="checkbox"/>	<input type="checkbox"/> C2	<input type="checkbox"/>
<input type="checkbox"/> C3/C4	<input type="checkbox"/>	<input type="checkbox"/> C3	<input type="checkbox"/>
<input type="checkbox"/> C4/C5	<input type="checkbox"/>	<input type="checkbox"/> C4	<input type="checkbox"/>
R <input type="checkbox"/> C5/C6	L <input type="checkbox"/>	R <input type="checkbox"/> C5	L <input type="checkbox"/>
<input type="checkbox"/> C6/C7	<input type="checkbox"/>	<input type="checkbox"/> C6	<input type="checkbox"/>
<input type="checkbox"/> C7/C8	<input type="checkbox"/>	<input type="checkbox"/> C7	<input type="checkbox"/>
		<input type="checkbox"/> C8	<input type="checkbox"/>
Thoracic			
<input type="checkbox"/> T1/T2	<input type="checkbox"/>	<input type="checkbox"/> T1	<input type="checkbox"/>
<input type="checkbox"/> T2/T3	<input type="checkbox"/>	<input type="checkbox"/> T2	<input type="checkbox"/>
<input type="checkbox"/> T3/T4	<input type="checkbox"/>	<input type="checkbox"/> T3	<input type="checkbox"/>
<input type="checkbox"/> T4/T5	<input type="checkbox"/>	<input type="checkbox"/> T4	<input type="checkbox"/>
<input type="checkbox"/> T5/T6	<input type="checkbox"/>	<input type="checkbox"/> T5	<input type="checkbox"/>
R <input type="checkbox"/> T6/T7	L <input type="checkbox"/>	R <input type="checkbox"/> T6	L <input type="checkbox"/>
<input type="checkbox"/> T7/T8	<input type="checkbox"/>	<input type="checkbox"/> T7	<input type="checkbox"/>
<input type="checkbox"/> T8/T9	<input type="checkbox"/>	<input type="checkbox"/> T8	<input type="checkbox"/>
<input type="checkbox"/> T9/T10	<input type="checkbox"/>	<input type="checkbox"/> T9	<input type="checkbox"/>
<input type="checkbox"/> T10/T11	<input type="checkbox"/>	<input type="checkbox"/> T10	<input type="checkbox"/>
<input type="checkbox"/> T11/T12	<input type="checkbox"/>	<input type="checkbox"/> T11	<input type="checkbox"/>
<input type="checkbox"/> T12/L1	<input type="checkbox"/>	<input type="checkbox"/> T12	<input type="checkbox"/>
Lumbar			
<input type="checkbox"/> L1/L2	<input type="checkbox"/>	<input type="checkbox"/> L1	<input type="checkbox"/>
<input type="checkbox"/> L2/L3	<input type="checkbox"/>	<input type="checkbox"/> L2	<input type="checkbox"/>
<input type="checkbox"/> L3/L4	<input type="checkbox"/>	<input type="checkbox"/> L3	<input type="checkbox"/>
R <input type="checkbox"/> L4/L5	L <input type="checkbox"/>	R <input type="checkbox"/> L4	L <input type="checkbox"/>
<input type="checkbox"/> L5/S1	<input type="checkbox"/>	<input type="checkbox"/> L5	<input type="checkbox"/>
<input type="checkbox"/> S1	<input type="checkbox"/>	<input type="checkbox"/> S1	<input type="checkbox"/>
Lumbar Epidural <input type="checkbox"/> Caudal ESI <input type="checkbox"/> Interlaminar <input type="checkbox"/>			

3 Allergies and Medication

4 Relevant Information

5 Referring Physician's Information

Name: _____
Address: _____
Phone: _____ Fax: _____
Signature: _____

Pregnant? Yes No LMP: _____ Diabetic Yes No

Physician's Stamp & Practice ID

URGENT STAT FAX REPORT (until 4 pm, M-F)

Copy To: Name: _____
Phone: _____
Fax: _____

FREE PARKING ALL SITES

**** ALL EXAMINATIONS ****

Remember to bring the Imaging Requisition plus your Alberta Health Card and photo ID. If you are unable to keep your appointment, please phone 780-669-2222 to reschedule it (There is no facility to look after small children.)

PATIENT INSTRUCTIONS

- Continue all medications and your usual diet both before and after the procedure.
- If you have an active infection your procedure will have to be rescheduled and you must notify our office (780-669-2222).
- If you are having special joint medication injected such as Synvisc, please check with Central Booking for cost of our Synvisc versus pharmacy. Cortisone and other medications are supplied by Insight.
- Please be advised, depending on your procedure, you may require a driver. When scheduling your appointment our booking agents will provide you with further instructions.
- Joint injections may take up to 30 minutes or longer to perform, depending on the injection site.
- You will be required to stay in the clinic for 15 minutes after the procedure to monitor your response to the injection.
- You should refrain from strenuous activity for at least a day after the injection. Also avoid hot tubs, swimming pools or prolonged bathing for the next 24 hours.
- You should also keep a record of your pain level on the accompanying pain diary (located on the right).
- If necessary, pain medication such as Tylenol or Advil can be used for discomfort after the injection (if you have no contraindications to these medications).
- Serious complications after joint injections are rare, but can occur. If you experience worsening pain over the next several days, fever and chills, other signs of infection or new numbness please contact your doctor or proceed to an emergency department.

PATIENT DIARY

Please record the following information as accurately as possible. This will help your doctor determine how successful the treatment was.

PAIN RECORD

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Imaginable

Site Injected: _____

Injection Date: _____

Injection Time: _____

PRE-INJECTION PAIN SCORE

Record your pain score at each of the following times below after your injection.

10 minutes:

Time: _____

Score: _____

Day 2:

Time: _____

Score: _____

2 Hours:

Time: _____

Score: _____

Day 3:

Time: _____

Score: _____

Day 1:

Time: _____

Score: _____

Day 7:

Time: _____

Score: _____

PAIN MANAGEMENT LOCATIONS

OLIVER SQUARE

11560 - 104 Avenue T5K 2S5
Ph: 780-486-8102 | F: 780-638-6241

MEADOWLARK

216 Meadowlark Health Centre
156 Street - 89 Avenue T5R 5W9
Ph: 780-489-8430 | F: 780-481-6630

CASTLEDOWNS

15309 Castle Downs Road T5X 6C3
Ph: 780-457-4070 | F: 780-456-1250

HERMITAGE NORTH

12779 - 50 Street T5A 4L8
Ph: 780-475-1866 | F: 780-478-0858

HERITAGE SOUTH

2049 - 111 Street NW T6J 4V9
Ph: 780-438-0547 | F: 780-438-9211

MILLWOODS

Main Street Mall
6466 - 28 Avenue NW T6L 6N3
Ph: 780-486-8103 | F: 780-638-6532

LEDUC

5307 - 50 Avenue T9E 6T2
Ph: 780-486-8104 | F: 780-638-6533

SHERWOOD PARK

136 Athabasca Avenue T8A 4E3
NE corner of Athabasca and Chippewa
Ph: 780-464-1515 | F: 780-464-1216

SPRUCE GROVE

107, 505 Queen Street T7X 2V2
Ph: 780-962-0297 | F: 780-962-8084



www.x-ray.ca

Please phone 780-669-2222 to schedule your appointment

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