ULTRASOUND–GUIDED INJECTION REFERRAL

SHIELD CLINICS

Pain Management & Spine Care

"healing from within"

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Patient Information

Patient Name:

Birth date (MM/DD/YYYY):

Address:

City:

Province: Postal Code:

Phone: Cell:

Email:

Gender: ☐ Male ☐ Female

PHN:

☐ Active WCB Claim Number:

Physician Information

Referring Physician:

PRACID:

Physician Address:

City:

Province: Postal Code:

Phone:

Email:

Fax:

Family Physician:

CLINICAL HISTORY

PROCEDURE REQUESTED

Therapy Choices

☐Diagnostic Block
☐Perineural Injection

☐Steroid / Cortisone*
☐Dextrose / Prolotherapy*
☐Ketorolac*

☐Viscosupplementation*
Specify: ____________

☐Platelet-Rich Plasma*

☐Calcific Tendon Barbotage
☐Needle Tenotomy / Scraping

☐Other: __________

Shoulder

☐Glenohumeral joint	R☐	L☐
☐AC joint	R☐	L☐
☐Subacromial bursa	R☐	L☐
☐Biceps tendon sheaths	R☐	L☐
☐Supraspinatus tendon	R☐	L☐
☐Infraspinatus tendon	R☐	L☐
☐Other: __________	R☐	L☐

Elbow

☐Elbow joint	R☐	L☐
☐Olecranon bursa	R☐	L☐
☐Lateral epicondylosis	R☐	L☐
☐Medial epicondylosis	R☐	L☐
☐Other: __________	R☐	L☐

Wrist & Hand

☐Radiocarpal joint	R☐	L☐
☐First CMC joint	R☐	L☐
☐Carpal tunnel	R☐	L☐
☐De Quervain's	R☐	L☐
☐Trigger finger: _________	R☐	L☐
☐Other: __________	R☐	L☐

Hip & Pelvis

☐Hip joint	R☐	L☐
☐Symphysis pubis	R☐	L☐
☐Iliopsoas bursa	R☐	L☐
☐Trochanteric bursa	R☐	L☐
☐Ischial bursa	R☐	L☐
☐Piriformis muscle	R☐	L☐
☐Other: __________	R☐	L☐

Knee

☐Knee joint	R☐	L☐
☐Baker's cyst	R☐	L☐
☐Patellar bursa	R☐	L☐
☐Pes anserine bursa	R☐	L☐
☐Other: __________	R☐	L☐

Ankle & Foot

☐Tibiotalar joint	R☐	L☐
☐Subtalar joint	R☐	L☐
☐First MTP joint	R☐	L☐
☐Plantar fascia	R☐	L☐
☐Achilles tendon	R☐	L☐
☐Other: __________	R☐	L☐

If possible, please provide a list of current medications and relevant medical information.

*These products are available at our clinic at additional costs.

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