

DATE OF REQUEST (D/M/Y): _____ APPT. DATE (D/M/Y): _____ TIME: _____

PATIENT INFORMATION

Name: _____ F M O
 Address: _____
 City/Province: _____ Postal Code: _____

Home Phone: _____
 Work/Mobile Phone: _____
 Date of Birth (D/M/Y): _____
 AHC: _____ WCB: _____

REASON FOR REFERRAL

Provide assessment and treatment plan

Diabetic: _____
 Pregnancy: Y N
 LMP: _____

Repeat Injection _____ (# of times/year)

Beam may perform pre-intervention X-ray of the region of interest for guidance and/or to rule out underlying pathology when indicated

MSK PROCEDURES

STEROID INJECTION PERFORMED UNLESS OTHERWISE INDICATED

SHOULDER

Acromioclavicular Joint R L
 Biceps Tendon R L
 Glenohumeral Joint R L
 Sternoclavicular Joint R L
 Subacromial Bursa R L

ELBOW

Elbow Joint R L
 Lateral Epicondyle R L
 Medial Epicondyle R L
 Olecranon Bursa R L

WRIST/HAND

1st CMC/MCP R L
 Carpal Tunnel R L
 De Quervain's Tenosynovitis R L
 Ganglion Cyst R L
 Radiocarpal Joint R L
 Trigger Finger R L

OTHER

Ganglion cyst (other sites) R L _____
 Tendon sheath injection R L _____
 Peripheral nerve injection R L _____
 Tenotomy R L _____
 Rotator cuff lavage R L _____
 Tendon neo-vessel injection R L _____
 Unspecified procedure R L _____

HIP AND PELVIS

Hip Joint R L
 Greater Trochanteric Bursa R L
 Iliopsoas Bursa R L
 Ischial Bursa R L
 Pubic Symphysis R L
 SI Joint R L

KNEE

Baker's Cyst Aspiration R L
 Knee Joint R L
 Other Site: _____

ANKLE/FOOT

Tibiotalar Joint R L
 Subtalar Joint R L
 Talonavicular Joint R L
 Calcaneocuboid Joint R L
 1st MTP Joint R L
 Morton's Neuroma R L
 Plantar Fasciitis R L
 Retrocalcaneal Bursa R L

SPINAL PROCEDURES


MECHANICAL/FOCAL PAIN RADICULOPATHY

Facet Joints Medial/Lateral Branch Block Nerve Root Block Radiofrequency Ablation

CERVICAL

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

THORACIC

R T1/2	L		R T1	L
R T2/3	L		R T2	L
R T3/4	L		R T3	L
R T4/5	L		R T4	L
R T5/6	L		R T5	L
R T6/7	L		R T6	L
R T7/8	L		R T7	L
R T8/9	L		R T8	L
R T9/10	L		R T9	L
R T10/11	L		R T10	L
R T11/12	L		R T11	L
R T12/L1	L		R T12	L

LUMBAR

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

SACRUM

R S1	L		R S1	L
R S2	L		Coccyx	

MUSCLE BLOCK

Piriformis
 Psoas Muscle
 Iliopsoas Muscle
 Quadratus Lumborum

Other: _____

EPIDURAL

Cervical
 Lumbar
 Interlaminar
 Caudal

OTHER INJECTABLES - UNINSURED SERVICES

Platelet-Rich Plasma (PRP)
 Viscosupplementation (Hyaluronic Acid)
 Botox-Specify location: _____
 Other Injectable _____

ALLERGIES

Contrast Dye Xylocaine Other: _____

MEDICATION

Anticoagulants (Plavix, Coumadin, Heparin) Other: _____

REFERRER INFORMATION

Name: _____ Prac ID: _____
 Address: _____
 Phone: _____ Fax: _____
 Copy to: _____

PHYSICIAN STAMP

PATIENT INFORMATION

Booking an Appointment

- Please advise us of any mobility issues.
- Notify booking if you are diabetic.
- We require two business days notice if you wish to reschedule or cancel your appointment(s). Please call **587.885.2988**

Day of Appointment

- Please remember to bring the requisition, your Alberta Health Care card and photo ID to your appointment.
- Please follow the appropriate exam preparation instructions below.

EXAM PREPARATION INSTRUCTIONS

Please arrive **15-20 minutes** prior to your appointment time.

There are no food or drink restrictions. Please have a small snack prior to your appointment.

Reduce any over-the-counter pain medication you may be taking on the day of your appointment. We need you to be in enough discomfort to assess whether the procedure has effectively reduced your pain. If you are still in discomfort with your pain medication, you do not need to discontinue use.

Take all other medications as prescribed by your physician.

If you are on **anticoagulants** (Heparin, Plavix, Coumadin), you may be required to have an INR and potentially stop taking these prior to your appointment. Please discuss this with your Beam booking coordinator.

ALL CORTICOSTEROID AND LOCAL ANESTHETIC ARE PROVIDED TO YOU AT YOUR APPOINTMENT.

IF YOUR DOCTOR HAS PRESCRIBED YOU WITH VISCOSUPPLEMENTATION MEDICATIONS (EX HYALURONIC ACID, ETC.) OR BOTOX, BEAM CAN SUPPLY THESE TO YOU FOR A REDUCED RATE AT OUR FACILITY. ALTERNATIVELY, YOU MAY BRING THESE WITH YOU TO YOUR APPOINTMENT.

You cannot have an **active infection or being treated for an active infection** on the day of your procedure (ie. taking antibiotics).

If possible, have someone accompany you to your procedure. In case you are in discomfort, it may be necessary to have someone else drive you.

You must bring a driver with you to your appointment if:

- you are having a Radiofrequency Ablation, an epidural injection or a nerve root block.
- you are having multiple sites injected

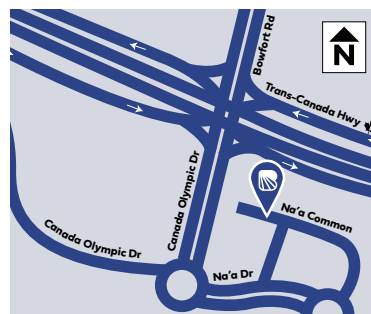
Failure to do so will result in your appointment being rescheduled.

It is normal to have an increase in your pain the day of and the day after your procedure.

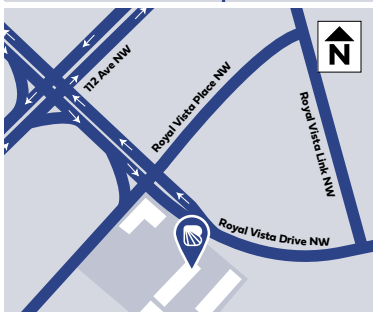
LOCATIONS



Harvest Hills
Suite 201, 178 96 Ave NE,
Calgary, AB T3K 6G4
Complimentary Parking
X-Ray, Ultrasound,
Pain Management



Trinity Hills
340 Na'a Common SW
Calgary, AB T3H 6A3
Complimentary Parking
MRI, CT, X-Ray, Ultrasound,
Pain Management



Royal Oak
Suite 3170, 11 Royal Vista Dr NW,
Calgary, AB T3R 0N2
Complimentary Parking
X-Ray, Ultrasound,
Pain Management



Canmore
Suite 108B, 1205 Bow Valley Tr
Canmore, AB T1W 1P5
Complimentary Parking
Ultrasound, Pain Management