CAMIS
Imaging Excellence

Central Alberta Medical Imaging Services
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MSK IMAGING AND INTERVENTION REQUEST FORM

PLEASE FAX A COPY OF THE REQUEST TO CENTRAL ALBERTA MEDICAL IMAGING SERVICES LTD. 403-309-0093

Patient Information

Name _____
Address _____
City _____
Province _____ Postal Code _____
Phone Home _____ Alt _____

DOB (D/M/Y) _____ M ☐ F ☐
A.H.C.# _____
WCB Claim # _____
Date of Injury (D/M/Y) _____

Clinical Information (required) _____

_____

Anticoagulation Yes ☐ No ☐ n/a ☐ **Anticoagulant Protocol attached?** (comment) _____

Allergy to radiographic contrast/x-ray dye/other medications Yes ☐ No ☐ Diabetic: Yes ☐ No ☐

Diagnostic Imaging

MSK Ultrasound *(to assess tendons, ligaments and muscles)*

Shoulder	☐ R ☐ L	Quadriceps	☐ R ☐ L
Elbow	☐ R ☐ L	Greater Trochanter Bursa	☐ R ☐ L
Wrist	☐ R ☐ L	Iliopsoas Bursa	☐ R ☐ L
Hand	☐ R ☐ L	Ankle	☐ R ☐ L
Achilles Tendon	☐ R ☐ L	Morton's Neuroma	☐ R ☐ L
Plantar Fascia	☐ R ☐ L	Knee *(Baker's cyst, patellar tendon, MCL, Pes Anserine)*	☐ R ☐ L
Other _____			

Soft Tissue Ultrasound *(to asses soft tissue mass)*

☐ Lipoma Area _____
☐ Ganglion Area _____
☐ Ganglion Aspiration and Injection

Other _____

If pathology is found in the area of interest you may expedite the patient's treatment. By checking the box below the patient will be booked for a therapeutic injection if appropriate.

☐ **Please proceed with appropriate therapeutic injection**

Interventional Procedures **some interventional procedures require prior imaging. This will be arranged by our office**

Prolotherapy *(min 3 treatments)*

Achilles Tendon	☐ R ☐ L
Lateral Epicondyle	☐ R ☐ L
Medial Epicondyle	☐ R ☐ L
Patellar Tendon	☐ R ☐ L

Special Procedures

Calcific Tendinopathy Barbatoge
_____ ☐ R ☐ L

Ganglion Aspiration and Injection
Area _____ ☐ R ☐ L

Steroid Injections

Shoulder Joint	☐ R ☐ L	Ankle Joint	☐ R ☐ L
Shoulder Bursa	☐ R ☐ L	Morton's Neuroma	☐ R ☐ L
AC Joint	☐ R ☐ L	Posterior Tibialis	☐ R ☐ L
Biceps Tendon Sheath	☐ R ☐ L	Peroneal Tendons	☐ R ☐ L
Elbow Joint	☐ R ☐ L	Knee Joint	☐ R ☐ L
Medial/Lateral Epicondyle	☐ R ☐ L	Pes Anserine Bursa	☐ R ☐ L
Carpal Tunnel	☐ R ☐ L	Hip Joint	☐ R ☐ L
Wrist Joint	☐ R ☐ L	Iliopsoas Bursa	☐ R ☐ L
Trigger Finger	☐ R ☐ L	Greater Trochanter Bursa	☐ R ☐ L
DeQuervain's	☐ R ☐ L	Other: _____	
Plantar Fascia	☐ R ☐ L		

CAMIS TECH NOTES ONLY

Technologist _____

Date of LMP _____ ☐ Menopause ☐ Hysterectomy ☐ Tubal Ligation

Referring Physician

Name _____
Address _____
Phone _____ Fax _____
PRAC ID _____
Signature _____

Copy To _____
Name _____