CAMIS
Imaging Excellence

Central Alberta Medical Imaging Services
4312 54th Avenue, Red Deer AB T4N 4M1

www.camisrd.com
Ph: 403-755-1052
Fax: 403-309-0093

VERTEBRAL AUGMENTATION REQUEST FORM

Patient's Name _____ A.H.C.# _____

Address _____ Date of Birth _____ M ☐ F ☐

City _____ Province _____ Phone Home _____ Alt _____

Postal Code _____

Diagnosis
☐ Vertebral Compression Fracture

Level: ☐ T5 ☐ T6 ☐ T7 ☐ T8 ☐ T9 ☐ T10 ☐ T11 ☐ T12 ☐ L1 ☐ L2 ☐ L3 ☐ L4 ☐ L5

☐ Compression Visible on X-ray

Fracture Type


☐ Wedge ☐ Bi-concave ☐ Crush

Probable Age of Fracture
☐ 1-4 Weeks ☐ 5-8 Weeks ☐ 2-6 Weeks ☐ 6 months & more

Possible Cause of Fracture
☐ Primary Osteoporosis ☐ Secondary Osteoporosis
☐ Osteolytic Lesion ☐ Trauma

Neurologic Deficit
☐ No ☐ Yes → ☐ Numbness
☐ Muscular Weakness

Available Imaging
☐ X-ray Only ☐ CT Scan
☐ MRI ☐ Bone Scan

*** Please attach all available reports and images to expidite the referral process**

Actual Patient State
☐ Acute pain ☐ Chronic pain

Level of pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Patient on bed rest
☐ Patient taking analgesics
☐ Patient taking narcotics

Physical Exam
☐ Tenderness at site (focal pain)
☐ Generalized back pain
☐ Possible neurological compromise (spinal cord compression)

Allergies
☐ Iodine allergy
☐ Other _____

Additional Data
☐ Patient on anticoagulants
☐ Patient on antiplatelet agent
☐ Patient respiratory compromised

Contra-indications
☐ Active infection

Bone Densitometry (DEXA)
☐ No
☐ Yes → Score/result _____
☐ Patient on antiresorptive therapy

Additional Comments
_____

_____

_____

Referring Physician _____ Physician Address _____

Signature _____ Phone _____ Date _____/_____/_____ (Year / Day / Month)