SYNERGY
Health and Sports Rehab

REQUISITION DATE

Please fax requisition to (844) 355 0016

Ultrasound-Guided MSK & Pain Procedures

Requisition

PATIENT INFORMATION

Patient Name **DOB** **Sex** M F

Health Card # **Phone** **Email**

CLINICAL INFORMATION

Relevant History / Indication (required) **PLEASE ATTACH COPIES OF ALL IMAGING REPORTS**

Relevant imaging available (XR / US / MRI)

ALLERGIES

Allergies (free text)

MEDICATIONS

Anticoagulation No Yes

Type(s)

INJECTION / PROCEDURE TYPE

The options of corticosteroid versus viscosupplementation will be discussed with the patient at the time of consultation.

PROCEDURES REQUESTED

UPPER EXTREMITY

R	L	Subacromial bursa
R	L	Glenohumeral joint
R	L	1st carpometacarpal (CMC) joint
R	L	1st metacarpophalangeal (MCP) joint
R	L	Lateral elbow (common extensor tendon)
R	L	Medial elbow (common flexor tendon)

LOWER EXTREMITY

R	L	Hip joint
R	L	Greater trochanteric bursa
R	L	Knee joint
R	L	Tibiotalar (ankle) joint
R	L	1st metatarsophalangeal (MTP) joint
R	L	Plantar fascia

REFERRING PROVIDER

Physician Name **OHIP Billing #**

Signature **Clinic Phone**

Clinic Fax