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Patient Label

REQUEST FOR ULTRASOUND-GUIDED INJECTION AND/OR ASPIRATION

For patients wishing non-surgical management of degenerative or repetitive strain MSK problems

Kindly note, I do not take referrals for axial skeleton issues, nerve pain, rheumatological diseases, fractures, acute infections, or complete tendon tears.

Referrer's Name: _____ Referrer's OHIP Code: _____

Patient Name: _____ Date of Referral: _____

Patient's Phone Number: _____ Patient's Email: _____

Side: Left Right Bilateral **CC:** Patient's Family Physician: _____

| | | |
|---|---|---|
| <p>Shoulder:</p> <input type="checkbox"/> AC Joint* <input type="checkbox"/> Biceps Tendon* <input type="checkbox"/> Glenohumeral Joint* <input type="checkbox"/> Frozen Shoulder* <input type="checkbox"/> Subacromial Bursa* <input type="checkbox"/> Rotator Cuff partial tear*§ <p>Elbow:</p> <input type="checkbox"/> Elbow Joint* <input type="checkbox"/> Lateral Epicondyle§ <input type="checkbox"/> Medial Epicondyle§ <input type="checkbox"/> Olecranon Bursa* | <input type="checkbox"/> Hip and Knee <input type="checkbox"/> Greater Trochanter Pain* <input type="checkbox"/> Knee Joint* <input type="checkbox"/> Baker's Cyst* <input type="checkbox"/> Lateral Knee/IT Band* <input type="checkbox"/> Medial Knee/Cyst* <input type="checkbox"/> Anterior Knee/Tendon*§ <p>Ankle</p> <input type="checkbox"/> Ankle Sprain*§ <input type="checkbox"/> Ankle Joint* <input type="checkbox"/> Achilles Tendon* <input type="checkbox"/> Plantar Fascia | <input type="checkbox"/> Wrist: <input type="checkbox"/> Radiocarpal Joint* <input type="checkbox"/> CMC Joint* <input type="checkbox"/> STT Joint* <input type="checkbox"/> Trigger Finger (D___) <input type="checkbox"/> 1 st Extensor Tendon <input type="checkbox"/> Intersection Syndrome <p>Miscellaneous:</p> <input type="checkbox"/> Trigger Point: _____ <input type="checkbox"/> 1 st MCP* <input type="checkbox"/> 1 st MTP* <input type="checkbox"/> Other: _____ |
|---|---|---|

Legend: * pre-appointment x-ray is recommended; § Soft Tissue Adapted Biocompatible Hyaluronic Acid (STABHA) can be helpful

Patient Preference (check all that apply):

Unsure Hyaluronic Acid STABHA§ Prolotherapy Tenotomy Corticosteroids

Patient Characteristics:

- Previous Failed Blind Injection
- Limited Mobility
- Requires Aspiration
- Diabetes
- Anticoagulation
- Orthopedic Hardware in area
- Fear of needles
- BMI > 40
- Urgent (Reason: _____)

Working Diagnosis:

Brief History:

Please attach patient profile, relevant imaging, and related consultations/notes.