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Patient Label

REQUEST FOR ULTRASOUND-GUIDED INJECTION AND/OR ASPIRATION

For patients wishing non-surgical management of MSK problems due to degeneration, repetitive strain or injury

Exclusions: axial skeleton issues, nerve pain, rheumatological diseases, fractures, infections, or complete tendon/ligament tears. Injection include Viscosupplementation, Prolotherapy, Tenotomy, and Corticosteroids. An X-ray of the joint is always appreciated.

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: _____

	Shoulder:		**Hip and Knee**		**Wrist/Hand:**
☐	AC Joint	☐	Knee Joint	☐	Radiocarpal Joint
☐	Long Head Biceps Tendon	☐	Baker's Cyst	☐	CMC Joint
☐	Glenohumeral Joint	☐	Greater Trochanter Pain	☐	STT Joint
☐	Frozen Shoulder	☐	Rectus Femoris	☐	Trigger Finger (D___)
☐	Subacromial Bursa	☐	Hamstrings	☐	1st Extensor Tendon
☐	Supraspinatus partial tear	☐	Medial Knee / MCL	☐	Intersection Syndrome
☐	Infraspinatus partial tear	☐	Lateral Knee / LCL	☐	TFCC / ECU
☐	Sternoclavicular Joint	☐	Anterior Knee Tendons	☐	Gamekeeper's Thumb
	Elbow:		**Ankle**		**Miscellaneous:**
☐	Elbow Joint	☐	Ankle Sprain	☐	1st MCP
☐	Lateral Epicondyle	☐	Ankle Joint	☐	1st MTP
☐	Medial Epicondyle	☐	Subtalar Joint	☐	Morton's/Midfoot
☐	Olecranon Bursa	☐	Achilles Tendon	☐	Trigger points
☐	Distal Biceps	☐	Plantar Fascia	☐	Other:_____

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:

Referrer's Signature:

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