



# VICTORIA ULTRASOUND-GUIDED INJECTION CLINIC

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## Referral for Ultrasound-Guided Injection

<u>Patient Information</u> (may attach label)		Referring MD :	Provider #
Last Name:	First Name:	Phone#:	Fax#:
OHIP#	D.O.B.	Email:	
Phone#	Email:	Clinic Address:	

Clinical History / Current Medications:	Recommended X-Ray Protocols
<p>Referring MD Signature: _____</p>	<p>*** If prior imaging is unavailable, please select the following as applicable. X-Ray services available on-site***</p> <p>R <input type="checkbox"/> L <input type="checkbox"/> Shoulder: AP / Lateral / AC Joints</p> <p>R <input type="checkbox"/> L <input type="checkbox"/> Elbow: AP / Lateral</p> <p><input type="checkbox"/> Bilateral Wrist/hand: AP / Lateral / Grip View</p> <p>R <input type="checkbox"/> L <input type="checkbox"/> Hip: AP Pelvis / Lateral / Dunn View</p> <p><input type="checkbox"/> Bilateral Knees: Weightbearing AP / 30 degree Lateral / Tunnel / Skyline</p> <p><input type="checkbox"/> Bilateral Ankles / Feet: Weightbearing AP/Lateral/Mortise</p>

## Procedure Requested

### THERAPY CHOICES:

- Diagnostic Block
- Steroid/Cortisone\*
- Dextrose/Prolotherapy\*
- Viscosupplementation\*
- Capsular Distention for Frozen shoulder
- Platelet Rich Plasma\*
- Calcific Tendon Barbotage
- Needle Tenotomy/Scraping
- Other: \_\_\_\_\_

\* Availalbe at Additional Cost

### SHOULDER

- Glenohumeral joint R  L
- AC joint R  L
- Subacromial bursa R  L
- Biceps tendon sheaths R  L
- Frozen shoulder R  L
- Other: \_\_\_\_\_

### ELBOW

- Elbow joint R  L
- Olecranon Bursa R  L
- Other: \_\_\_\_\_ R  L

### WRIST & HAND

- Radiocarpal joint R  L
- First CMC joint R  L
- De Quervain's R  L
- Ganglion Cyst R  L
- Carpal Tunnel Syndrome R  L
- Other: \_\_\_\_\_

### HIP & PELVIS

- Hip joint R  L
- Symphysis pubis R  L
- Iliopsoas bursa R  L
- Trochanteric bursa R  L
- Other: \_\_\_\_\_ R  L

### KNEE

- Knee joint R  L
- Baker's cyst R  L
- Meniscus Tear R  L
- Other: \_\_\_\_\_

### ANKLE & FOOT

- Tibiotalar joint R  L
- Subtalar joint R  L
- First MTP joint R  L
- Other: \_\_\_\_\_ R  L

## Victoria Ultrasound-Guided Injection Clinic

Dept. of Victoria Medical Group  
 Unit 201, 1252 Lawrence Avenue East  
 North York, ON M3A 1C3  
 Tel: 416 609 1100 Fax: 416 609 1102

Please Fax Referral to:  
**416 609 1102**  
 X-Ray and Ultrasound Services  
 Availalbe On-site