

Patient Information

Name _____
 DOB _____ Male Female Other
 Address _____
 City/Province _____
 Phone _____
 PHN# _____

Relevant History Repeat Injection ____ X of times/year

Injectables

Prolotherapy Monovisc/Orthovisc
 Corticosteroids Cingal
 Platelet Rich Plasma (PRP) Sport Vis

Peripheral Procedures

Shoulder		Ankle/foot	
<input type="checkbox"/> Subacromial bursa	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Tibiotalar joint	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Glenohumeral joint	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Subtalar joint	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> AC joint	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Talonavicular joint	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Biceps tendon	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Calcaneocuboid joint	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Other: _____		<input type="checkbox"/> 1st MTP	<input type="checkbox"/> R <input type="checkbox"/> L
Wrist/Hand		<input type="checkbox"/> Retrocalcaneal bursa	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Radiocarpal joint	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Plantar Fasciitis	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> 1st CMC joint	<input type="checkbox"/> R <input type="checkbox"/> L	Knee	
<input type="checkbox"/> Carpal tunnel	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Knee joint	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Trigger finger	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Genicular nerve block	<input type="checkbox"/> R <input type="checkbox"/> L
Elbow		<input type="checkbox"/> Bursa: _____	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Elbow joint	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Bakers cyst	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Lateral epicondylitis	<input type="checkbox"/> R <input type="checkbox"/> L		
<input type="checkbox"/> Medical epicondylitis	<input type="checkbox"/> R <input type="checkbox"/> L		
Other			
<input type="checkbox"/> Ganglion cyst	<input type="checkbox"/> R <input type="checkbox"/> L _____		
<input type="checkbox"/> Tendon sheath	<input type="checkbox"/> R <input type="checkbox"/> L _____		
<input type="checkbox"/> Peripheral nerve	<input type="checkbox"/> R <input type="checkbox"/> L _____		
<input type="checkbox"/> Tenotomy	<input type="checkbox"/> R <input type="checkbox"/> L _____		
<input type="checkbox"/> Hydrodissection	<input type="checkbox"/> R <input type="checkbox"/> L _____		

Referring Provider

Provider name _____
 Signature _____
 Phone _____
 Address _____

Patient details

Pregnant Anticoagulation
 Breastfeeding
 History of diabetes

Spinal Procedures - Previous imaging required

Cervical		Specify level
<input type="checkbox"/> Facet joint	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Nuchal ligament	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Lamina	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Transverse process	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Spinous process/ligament	<input type="checkbox"/> R <input type="checkbox"/> L	_____
Thoracic		
<input type="checkbox"/> Facet joint	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Costotransverse joint	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Transverse rocess	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Spinous rocess	<input type="checkbox"/> R <input type="checkbox"/> L	_____
Lumbar		
<input type="checkbox"/> Facet joint	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Transverse process	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Lumbar lamina	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Ilio-lumbar ligament	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Spinous process	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Interspinous ligament	<input type="checkbox"/> R <input type="checkbox"/> L	_____
Sacrum/Coccyx		
<input type="checkbox"/> SI joint	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Sacrococcygeal ligament	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Sacrotuberous ligament	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Posterior superior iliac	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Posterior sacroiliac ligament	<input type="checkbox"/> R <input type="checkbox"/> L	_____
<input type="checkbox"/> Caudal epidural		_____

- A client coordinator will contact your patient to schedule your appointment.
- All pain management services provided are **not** covered by Alberta Health Care from the Nurse Practitioner. You may be eligible to have your procedure covered by insurance.
- **Please bring** your health card, photo ID and this requisition form to your appointment.
- **Please arrive 10 minutes prior to your appointment.**
- All intra-articular medications (corticosteroids and hyaluronic acid) are provided to you at your appointment.
- Patients are allowed to leave after their procedure with no down time required. Exception: any spinal procedure will require an additional 15 minutes to recover. **Epidural patients must have a driver.**
- Please contact us if you have any questions.

1819 4th Street SW, Calgary, AB T2S 1W2

www.fixxinjections.com

Email: info@fixxinjections.com

Phone: 825-982-1666 Fax: 855-583-2330

Fee Schedule - General Procedures

Consultation \$250 - 60 minutes

The consultation may take up to 60 minutes and includes history taking, imaging review, pertinent physical exam findings, diagnostic testing and treatment planning

Cortisone/Steroid

- 1 joint injection site - \$185
- 2 joint injection sites - \$350
- Additional injections after 2 - \$125

Hyaluronic acid

- Monovisc - \$575
- Cingal - \$595
- Orthovisc x3 - \$200 per injection
- Sport Vis x2 - \$235 per injection

Platelet-Rich Plasma (PRP)

- 1 injection - \$650
- 3 injections - \$1755

Prolotherapy

- 1 session - \$250
- 3 sessions - \$675

Fee Schedule - Advanced Procedures

Spinal procedures

Cortisone/Steroid

- Lumbar - \$250 per site
- Thoracic - \$250 per site
- Cervical - \$300 per site
- 2 injection sites - x 1.5 base cost
- Additional injections after 2 - \$125

Platelet-Rich Plasma (PRP)

- 1 injection - \$650
- 3 injections - \$1755

Prolotherapy

- 1 session - \$250
- 3 sessions - \$675

FIXX
PAIN MANAGEMENT INJECTIONS

All costs exclude GST