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# THERAPEUTIC INJECTION REQUISITION

**Please complete all 3 parts and submit by email or fax**

## PART 1 PATIENT AND PHYSICIAN INFORMATION

| | |
|---|---|
| **PATIENT NAME:**<br>Last First Middle | **REFERRING PHYSICIAN NAME:**<br><br>Billing # |
| **ADDRESS:** | **ADDRESS:** |
| **PHONE:** Home Other | **PHONE:** |
| **EMAIL:** | **FAX:** |
| **DATE OF BIRTH:** yyyy/mm/dd **SEX:** [ ]M [ ]F | **Additional Copies to:** |
| **PHN:** **WEIGHT:** | |

## PART 2 MEDICAL

**THERAPEUTIC INJECTION REQUESTED:**

Please provide details such as:
L/R side, injectate type and dose, etc.

## PART 3 PATIENT SCREENING

| | |
|---|---|
| Can the patient give consent ? | Yes / No |

For the questions below, any yes answer requires details in the NOTES section.

| | |
|---|---|
| Drug allergies ? | Yes / No |
| Bleeding dyscrasias ? | Yes / No |
| Anticoagulation medications ? | Yes / No |
| Interpreter needed ? | Yes / No |

**CLINICAL HISTORY:**

**NOTES:**

**RELEVANT PRIOR EXAMS:** (e.g. MRI, CT, Nuc Med, X-Ray, Angiogram, Other)

**PHYSICIAN SIGNATURE:**