

Check the treatment(s) you prescribe or request, sign, and fax or email with the most recent imaging report. An X-ray or MRI confirming the diagnosis is required before any joint injection. All injections are given under real-time ultrasound guidance at MedCAiRE Oakville.

1. PATIENT

Last name 	First name 	Date of birth (DD/MM/YYYY) 	Health card # / version
Phone 	Email 	Address (street, city, postal code) 	

2. REFERRING PROVIDER

Provider name 	Designation ☐ GP / Family MD ☐ NP ☐ Specialist	CPSO / CNO # 	OHIP billing # (if applicable)
Clinic name & address 	Phone 	Fax 	Email

3. TREATMENT PRESCRIBED / REQUESTED (CHECK ALL THAT APPLY)

☐ PRP Platelet Rich Plasma: single injection Tendon, ligament or early joint conditions	☐ PRP Platelet Rich Plasma: 2-injection protocol Spacing set at assessment
☐ PRP nSTRIDE® APS: single knee injection Mild to moderate knee osteoarthritis	☐ MonoVisc®: 88 mg cross-linked HA / 4 mL, single injection OA of knee, hip, shoulder or ankle
☐ Cingal®: 88 mg HA + 18 mg triamcinolone hexacetonide / 4 mL Knee OA. Contains a corticosteroid	☐ SportVis™: 2 injections of 1.2 mL STABHA™ HA Chronic tennis elbow, grade 1–2 ankle sprain
☐ Assess and recommend: MedCAiRE to recommend the most appropriate option	
Site: ☐ Knee ☐ Hip ☐ Shoulder ☐ Ankle ☐ Elbow ☐ Tendon / ligament Side: ☐ L ☐ R ☐ Bilateral Other site	

4. CLINICAL INFORMATION

Diagnosis / reason for referral 	OA grade (e.g. KL 1–4), if known
Imaging: ☐ X-ray ☐ MRI ☐ Ultrasound ☐ Report attached	
Treatments tried: ☐ Physio ☐ Acetaminophen / NSAIDs ☐ Corticosteroid injection ☐ HA injection ☐ PRP	
Imaging date 	Prior injections: product, joint and dates

5. SAFETY SCREENING (CHECK IF PRESENT)

☐ Allergy to hyaluronic acid / avian / bacterial products	☐ Anticoagulant / antiplatelet therapy
☐ Bleeding disorder or low platelets	☐ Skin or joint infection at injection site
☐ Pregnant or breastfeeding	☐ Diabetes (relevant to Cingal® steroid)
☐ Immunosuppression / active cancer treatment	☐ Steroid injection in this joint within 3 months
Allergies & current medications 	

6. PRESCRIBER AUTHORIZATION

I have assessed this patient and prescribe / request the treatment(s) checked in Section 3. MedCAiRE will confirm suitability at assessment, coordinate product and booking, and send a treatment summary back to me.

Prescriber signature 	Printed name 	Date
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Send to MedCAiRE: Fax 905.848.8252 · Tia@MedCAiRE.ca · Alternate Filipe@MedCAiRE.ca

Include the most recent imaging report. We contact the patient to book and keep you updated on the plan and outcome.