MEDCAiRE HEALTH

Regenerative Injection Referral & Prescription

PRP · nSTRIDE® APS · MonoVisc® · Cingal® · SportVis™

FAX 905.848.8252 · Tia@MedCAiRE.ca · Tel 905.848.3010

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 | CPSO / CNO # | OHIP billing # (if applicable)

☐ GP / Family MD ☐ NP ☐ Specialist

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

Site: ☐ Knee ☐ Hip ☐ Shoulder ☐ Ankle ☐ Elbow ☐ Tendon / ligament

Side: ☐ Left ☐ Right ☐ 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 (DD/MM/YYYY) | 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 (DD/MM/YYYY)

Send to MedCAiRE: FAX TO: 905.848.8252 · Tia@MedCAiRE.ca · Filipe@MedCAiRE.ca

Include the most recent imaging report.