St Vincent's Health Lithotripsy Service November 2008
Ph 9288 3628
Fax 9288 3627

ESWL Referral Form

NAME……

ADDRESS……

DOB……

Phone……

PLEASE COMPLETE ALL SECTIONS OF THIS FORM TO ENSURE YOUR PATIENT IS TREATED ASAP
IMAGING REPORTS MUST ACCOMPANY THIS REFERAL

REFERRAL FOR TREATMENT OF: _____

SIDE SELECTED FOR TREATMENT – RIGHT / LEFT (PLEASE CIRCLE)

NO. OF STONES ……

SIZE OF STONES……

STONE TYPE - OPAQUE / NON OPAQUE ON PLAIN FILM

STENT INSERTED YES / NO

IF YES DATE STENT INSERTED:

……

PCNL YES / NO DATE :……

INVESTIGATIONS TO BE DONE
PRIOR TO REFERRAL BEING SENT:

MSU, U& E, FBE, INR DATE……

PLAIN KUB **MANDATORY** DATE……

IVP YES / NO DATE……

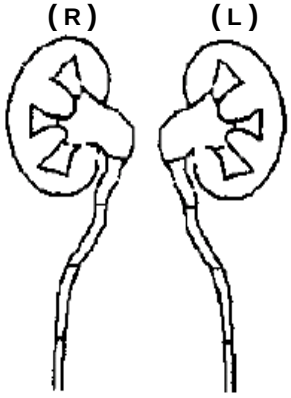
(IF STONE NOT RADIO-OPAQUE)
ULTRASOUND YES / NO DATE……

CT SCAN YES / NO DATE……

REPORTS FOR XRAYS AND TESTS TO ACCOMPANY

REFERRAL TO ENSURE PROMPT TREATMENT

POSITION OF STONE



PLEASE NOTE: IF BILATERAL STONES, PLEASE INDICATE WHICH SIDE TO TREAT FIRST

GENERAL HEALTH

DIABETES YES / NO

PACEMAKER YES / NO

WARFARIN YES / NO

ASPIRIN / NSAID YES / NO

PREADMISSION CLINIC REQUIRED YES / NO

INTERPRETER REQUIRED YES / NO

LANGUAGE ……

REFERRING DOCTOR ……

REFERRING HOSPITAL IF APPLICABLE ……

COMMENTS / ADDITIONAL INFORMATION ……

……
(IF PATIENT HAS A COMPLEX HISTORY PLEASE ENCLOSE A DETAILED LETTER WITH INVESTIGATIONS)

DOCTOR'S NAME AND SIGNATURE……

DATE……