ST VINCENT'S HOSPITAL
MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

ST. VINCENT'S MELBOURNE

EXTRACORPOREAL SHOCKWAVE LITHOTRIPSY REFERRAL FORM

UR No.: ____________________

Surname: ____________________

Given Name: ____________________

D.O.B.: ____________________

Please fill in if no Patient Label available

Please complete all sections of this form to ensure your patient is treated ASAP.
Imaging reports must accompany this REFERRAL

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

NO. OF STONES: ....

SIZE OF STONES: ....

STONE TYPE: OPAQUE / NON OPAQUE ON PLAIN FILM

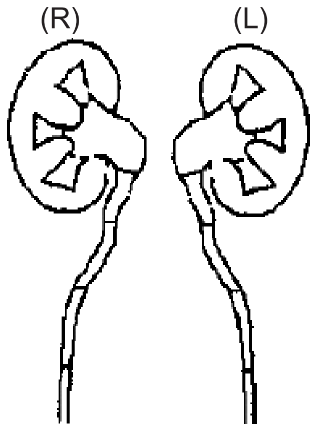
STENT INSERTED: YES / NO

IF YES, DATE STENT INSERTED:

....

PCNL: YES / NO DATE: ....

POSITION OF STONE



PLEASE NOTE: if bilateral stones please indicate which side to treat first.

INVESTIGATIONS TO BE DONE
PRIOR TO REFERRAL BEING SENT:

MSU, U&E, FBE DATE: ....

INR if clinically indicated

CT SCAN: YES / NO DATE: ....

PLAIN KUB: YES / NO DATE: ....

ULTRASOUND: YES / NO DATE: ....

ECG (patients >50 years)

Reports for x-rays and tests to accompany referral to ensure prompt treatment.

GENERAL HEALTH

DIABETES	YES / NO
PACEMAKER	YES / NO
WARFARIN / ANTICOAGULANTS	YES / NO
ASPIRIN / NSAID	YES / NO
PREADMISSION CLINIC REQUIRED	YES / NO

INTERPRETER REQUIRED YES / NO

LANGUAGE: ....

REFERRING DOCTOR / HOSPITAL: ....

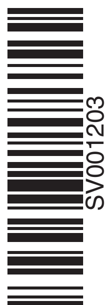
COMMENTS / ADDITIONAL INFORMATION: ....

....

(To discuss suitability of your patient for lithotripsy, please contact office on 9231 3628)

DOCTOR'S NAME AND SIGNATURE: ....

DATE: ....



St. Vincent's Health Lithotripsy Service April 2018
Tel: 9231 3628
Fax: 9231 3627

EXTRACORPOREAL SHOCKWAVE LITHOTRIPSY REFERRAL FORM - ST. VINCENT'S MELBOURNE