St Vincent's Health Lithotripsy Service July 2015
Ph 9231 3628
Fax 9231 3627

ESWL Referral Form

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

NAME……..……..……..

ADDRESS……..……..

DOB…….……..……..

Phone…….……..……..

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

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……

CT SCAN **MANDATORY** DATE……

PLAIN KUB YES / NO DATE……

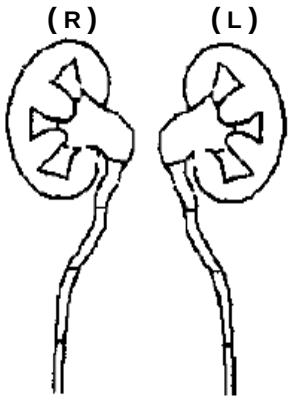
IVP YES / NO DATE……

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

ECG (patients 50 years & over 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 / HOSPITAL ……

COMMENTS / ADDITIONAL INFORMATION ……

……

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

DOCTOR'S NAME AND SIGNATURE……..

DATE……..