EXTRACORPOREAL SHOCKWAVE THERAPY – ORTHOPAEDIC

Bupa CROMWELL HOSPITAL

PLEASE NOTE: INCOMPLETE REFERRALS WILL BE SENT BACK TO THE REFERRER

For completion by referring clinician.
Please email to lithotripsy@cromwellhospital.com
Direct Fax: +44 (0)20 7835 2402
Telephone: +44 (0)20 7244 4860

London Lithotripter Centre
Bupa Cromwell Hospital 164-178
Cromwell Road
London SW5 0TU

Patient's name:
DOB: Sex F ☐ M ☐
Telephone number:
Has patient consented to be contacted by telephone? Yes ☐ No ☐
Email:
Has patient consented to be contacted by email? Yes ☐ No ☐
Please tick if you can provide: Imaging ☐ Imaging report(s) ☐
(For office use only) MRN No..... 1st ESWT Tx ☐ Date ..... 2nd ESWT Tx ☐ Date ..... 3rd ESWT Tx ☐ Date.....

Absolute Contraindications

1. Pregnancy
2. Epiphyses within treatment zone
3. Malignant disease

Relative Contraindicationschecklist

Anticoagulant/platelet Therapy Yes ☐ No ☐

(i.e. Aspirin, Warfarin, Clopidogrel, Rivaroxaban, Apaxiban, ticagrelor, prasugrel)

CLINICAL INFORMATION		
1. Diagnosis:		
2. Site to be treated		
3. Side to be treated (please circle):	L	R
4. Any previous Extracorporeal Shockwave Therapy? (please circle):	Y	N
5. Any previous steroid injection?	Y	N
6. Any previous Platelet Rich Plasma injection?	Y	N
7. Is the Patient diabetic?	Y	N
Any other relevant information?:		

Referring Clinician name (please print)		
Telephone Number.....	GMC number.....	Date.....
Referring Clinician signature		

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