**Please ensure patients have had recent (within 28 days) imaging to confirm presence of stone.**

**For patients diagnosed on CT, this should also include a contemporary plain KUB Xray.**

**Guy’s Lithotripsy Referral Form**



Referring hospital:

Referring consultant:

GP name:

GP adress:

GP phone number:

Patient forename:

Patient surname:

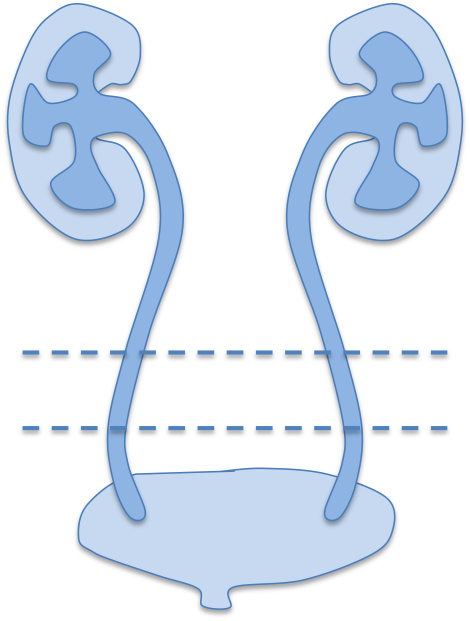
Date of birth (dd/mm/yy):

Sex: Male  Female

NHS number:

Local hospital number:

**Stone to be treated**



Address:

Home phone number:

Mobile phone number:

**Priority:** Urgent  Non-Urgent

Any physical disability or incapacity?

YES (state)

Weight (kg):

Obese? YES

**Previous treatment**

Lithotripsy: YES

Ureteroscopy: YES

PCNL: YES

**Stones** (please describe if unable to mark diagram):

**Please complete all sections and return to: guysstoneunit@nhs.net**

**Exclusion criteria** (if any YES, then not suitable for ESWL)

Anticoagulants (including aspirin): YES (state)

Pacemaker: YES

Uncontrolled hypertension: YES

Abdominal aortic aneurysm: YES

Pregnancy: YES

**Present symptoms**

Side (please check one box only):

Right  Left  Both

Pain: YES

Infection: YES

Stent in situ: YES

Other information: