MonashImaging
UROLOGY

CASEY LITHOTRIPTER CONSULTATION

Identify

Patient Name
(Affix Patient's ID label here)

DOB: **M / F** **Contact**

Interpreter needed? Yes ☐

Language? ____________________

Private Insurance Yes / No

Requester Details. Please note that incomplete forms will be returned.

(Print) Name ____________________ Contact details ____________________

Provider number ____________________ Referring Hospital if applicable ____________

Situation

Clinical Details: If bilateral stones, please indicate which side to treat first.

No of Stones ____________________

Size of Stones: ____________________

Stone type: Opaque

Non-opaque on plain film

Stent inserted Yes/No

If yes: date of insertion: ____________________

Previous stones Yes/No Date: ________

Position of stone

(R) (L)

Please detail Imaging Provider and if not available on PACS all films or discs to accompany referral.
Incomplete forms will be returned

Investigations to be done prior to referral being sent

Background

MSU	Date:	Provider
Plain KUB	Date:	Provider
CT KUB/IVP	Date:	Provider

General Health		**Allergies:**	
Diabetes	Yes / No	Aspirin / NSAID	Yes / No
Pacemaker	Yes / No	Pre-admission Clinic required	Yes / No
Ehlers-Danlos syndrome	Yes / No	Warfarin/Anticoagulants	Yes / No

Assessment

All referrals will be discussed at a stone meeting prior to treatment. If felt appropriate patients will be offered alternative treatments or included in clinical trials. If you do not agree please tick here. ☐

Patients will be offered review and retreatment at Monash Health. If you do not agree please tick here. ☐

Request

Referral for the treatment of ____________________

Side selected for treatment: Please circle: Right / Left

I verify that this is the correct patient, correct side and site of stone:

____________________ Date: ____________

Signature of Requester

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