Lithotripsy Manual Booking Form - St. Joseph's Hospital
1-800-461-6674 or 519-646-6168 Fax: 519-646-6231

◯ Urgent or ◯ Elective

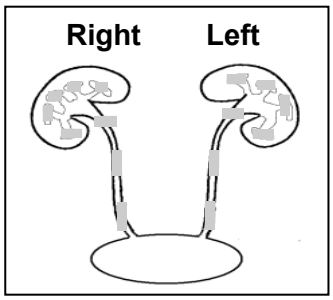
Doctor's name and contact information to be added here

Patient Surname:		First Name:	
Date of Birth (YYYY/MM/DD)			
Address:		City:	Postal Code:
Telephone #:		Alternate #:	
Ontario Health Card #:		Version Code:	
Family Doctor Name:		Telephone #:	

Please provide the following patient information & indicate on the diagram the location(s) of the stone

Bilateral ESWL is not routinely performed. Please indicate treatment side

- ☐ Right ESWL or ☐ Left ESWL
- ☐ Are you requesting a Stent Insertion?
- ☐ Patient is stented
- ☐ Retreatment



Imaging results must be included with the referral or referral cannot be completed and scheduling will be delayed until received.

Please note a KUB alone for the initial referral is not satisfactory. Either a KUB and ultrasound or a CT KUB are required. Must have been completed in the last 90 days

Does the patient take ASA? ◯ yes ◯ no
Does the patient have a pacemaker? ◯ yes ◯ no
Does the patient have a history or a family history of malignant hyperthermia? ◯ yes ◯ no

A current urine C&S is required to be submitted with the referral.

If a new sample is being collected, please include our fax # 519-646-6231 and cc St. Joseph's lithotripsy on the requisition to facilitate us receiving the results.

Reminders:

- Fax the **completed 2-page** preoperative patient questionnaire with the booking form
- Fax a copy of the most recent clinic note
- Please indicate your patient's preference for communication by checking one of the boxes below
  - ◯ Patient has indicated they do wish to receive notification by email
  - ◯ Patient has indicated they **do not** wish to receive any notification by email