|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SHOCKWAVE REFERRAL | | | |  | | |
| Please complete and email to: Therapiesbookinghub at [Therapiesbookinghub@stgeorges.nhs.uk](mailto:Therapiesbookinghub@stgeorges.nhs.uk)  Appointment queries please call CBS on 0208 725 0007  \*Patients must satisfy ALL inclusion/exclusion criteria below | | | | | | |
| **REFERRER’S DETAILS: Please complete IN CAPITALS** | | | | | | |
| Name:  Designation: | | | Referrer address:  Contact e-mail:  Tel no: | | | |
| **PATIENT’S GP / PCT DETAILS: Please complete IN CAPITALS** | | | | | | |
| GP Name: (PRINT) | | | Surgery Address: (PRINT) | | | |
| **PATIENT’S DETAILS: Please complete IN CAPITALS** | | | | | | |
| SGH HOSPITAL NO: | | NHS NUMBER: | DOB: | | SEX: | |
|  | |  |  | | Male 🞏 | Female 🞏 |
| PATIENT’S SURNAME: | | | PATIENT’S FULL ADDRESS: | | | |
|  | | | POSTCODE: | | | |
| PATIENT’S FORENAME: | | |  | | | |
|  | | |  | | | |
| Patient Tel no: |  | |  | | | |
|  |  | | INTERPRETER REQUIRED?  If Yes, which Language? | | Yes 🞏 No 🞏 | |
| **CONSENT TO LEAVE TELEPHONE MESSAGE?** | | Yes 🞏 No 🞏 |  | |  | |
| DIAGNOSIS AND DETAILS OF MANAGEMENT TO DATE:    DATE OF ONSET: | | | ULTRASOUND / MRI FINDINGS (please include type of scan and date):  \*Please ensure imaging is uploaded to SGH PACS/attached to referral | | | |
| **Inclusion Criteria:** | | Tendinopathy confirmed on imaging? Yes 🞏 No 🞏  Optimised conservative management? Yes 🞏 No 🞏  (Including physiotherapy/podiatry input and patient adhering to advice/exercise) | | | | |
| **Exclusion Criteria:** | | Infection at treatment site? Yes 🞏 No 🞏  Pregnancy? Yes 🞏 No 🞏  Epilepsy? Yes 🞏 No 🞏  Malignant tumor in the treatment area? Yes 🞏 No 🞏  Cemented joint replacement at site? Yes 🞏 No 🞏  Steroid injection within the last 12 weeks? Yes 🞏 No 🞏  Significant tears identified on imaging? Yes 🞏 No 🞏  Poor sensation or hypersensitivity in the target area? Yes 🞏 No 🞏 | | | | |
| **Precautions:** | | Anticoagulation therapy? Yes 🞏 No 🞏  Blood clotting disorder? Yes 🞏 No 🞏  Cardiac pacemaker? Yes 🞏 No 🞏  \*If yes please ensure the patient has checked with their relevant medical team and they are happy for them to proceed with SWT and document this clearly on the referral. | | | | |
| **Further Information:** | | \*Please advise patient to stop any anti-inflammatory medication 48hrs prior to assessment | | | | |
| REFERRER’S SIGNATURE: | | | DESIGNATION: | | | |

For any queries regarding the shockwave therapy service contact:

mskphysioenquiries@stgeorges.nhs.uk SGH, Ext: 1422