|  |  |
| --- | --- |
| SHOCKWAVE REFERRAL |  |
| Please complete and email to: Therapiesbookinghub at 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