



Patient ID

The Kidney Stone Centre
SWL Treatment / Consultation Requisition

Fax Requisition to: (416) 864-3045
Telephone: (416) 864-3044
Fax Lab Results to: (416) 864-3048
1-800 263 2885

Please check one: SWL Treatment [] Consultation: [] For the Kidney Stone Prevention Clinic please call: 416-867-7460 ext.48114

Patient Information

Last Name: _____ First Name: _____
Tel. (Home/cell): _____ Tel. (Business): _____
Address: Street _____ Apt No. _____
City _____ Province _____ Postal Code: _____
Date of Birth (D.M.Y) _____ Male [] Female [] Other []
Health Card No. _____ Version Code: _____

Please indicate if applicable:

- [] Diabetic Takes Insulin [] Yes [] No [] Cardiac Disease [] Nephrostomy Tube [] Solitary Kidney
[] Infected Stones [] Obstruction without stent [] Paediatric [] Wheelchair dependant/Bedridden
Please comment: _____

Stone Information: Please draw in all stones and stents. Measure two dimensional size (in mm) and indicate with an arrow -> which stone this represents:

Right Side:

Stone present: [] Yes [] No
Stent present: [] Yes [] No

Size (mm)

_____ x _____
_____ x _____
_____ x _____
_____ x _____

Left Side:

Stone present: [] Yes [] No
Stent present: [] Yes [] No

Size (mm)

_____ x _____
_____ x _____
_____ x _____
_____ x _____



For bilateral stones,
side to be first: [] Left [] Right

Lithotripsy Treatment Checklist

- CT within one year
• KUB (within 1 month)
• Urine C & S*
• Electrolytes (If Diabetic or on diuretics)*
*Within 28 days of treatment
(All positive Urine C&S to be treated)
• Cardiac / Medical Reports (If applicable)*
• ASA and NSAID stopped (Within 7 days)*
• Anticoagulants / antiplatelet (Stop as recommended by physician)*
• ECG (If cardiac disease, arrhythmia, hypertension, diabetes on insulin, cerebrovascular disease and/or serum Cr. >180)*

Referring Urologist: _____
phone #: _____
fax #: _____
Date: _____
Comment / History

For St. Michael's Hospital Use Only

Treatment date: _____
Time: _____
Reviewed by Dr. _____
Recommendations (if any)

