St Helens and Knowsley Teaching Hospitals NHS Trust

UROLOGY STONES CLINIC REFERRAL FORM

PATIENT NAME: _____

PATIENT ID: _____

PATIENT DOB: _____

PATIENT ADDRESS: _____

_____

PATIENT CONTACT TELEPHONE: _____

BRIEF CASE DESCRIPTION AND CT KUB/USS RESULTS:

U & E RESULTS: _____

URINE DIPSTICK: _____

REFERRING CLINICIAN: _____

GRADE: _____

DATE OF REFERRAL: _____

REMEMBER EXCLUSION CRITERIA – REFER TO SPECIALTY

- RENAL IMPAIRMENT
- EVIDENCE OF INFECTION
- UNCONTROLLABLE PAIN
- OTHER MORE LIKELY DIAGNOSIS
- ABNORMAL FAST SCAN

EXCLUSION CRITERIA: RENAL FAILURE, INFECTION, ONGOING PAIN

This form must be scanned and e-mailed to stone.clinic@sthk.nhs.uk