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Vancouver, BC V5Z 3X7
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treatment for tendinitis
Sonorex

ESWT Treatment Request Form

PATIENT INFORMATION

Name: ____
(Last) (First) (Initial)

Phone No.: ________________________

REFERRAL INFORMATION

Referred by: ____
(Name) (Title)

Professional Address: ____

Office Phone No.: ______________________Office Fax No.: _____________________

Diagnosis: ____

ESWT requested for treatment site: ____________________________________

RECENT IMAGE FINDINGS X-Ray, CT, MRI (must be current within 90 days)

NOTE **Do not leave blank as patients will not be treated without reference to imaging.**

______ Radiology Report attached and/or copy has been provided to the patient;
(Initial) or…

______ I have evaluated this patient and in my professional opinion, no imaging studies are required.
(Initial)

- **Females who are PREGNANT cannot be treated**
- **Patient must be free of CORTISONE injections 6 weeks prior to treatment**
- **Patient must not be taking blood thinning medications (i.e COUMADIN)**

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Referring physician's/physiotherapist's signature

Date:________________________________

(Referral valid for 90 days)