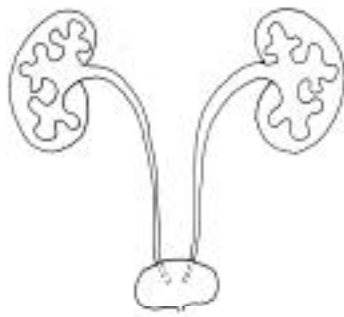


POST-OP RESULTS - ALL INFORMATION IS REQUIRED. PLEASE COMPLETE LEGIBLY.

Section A	Is the patient free of the <u>treated stone(s)</u> as a result of the ESWL treatment at the Kidney Stone Center?				
	<input type="checkbox"/> Yes: Imaging study date& type used to verify: _____				
	<input type="checkbox"/> No: Please complete table below (required).				
	IMAGING STUDY TYPE	Date	FRAGMENTS		
			Side	Width x Length	Location



Section B	If stent was in place at discharge from the Kidney Stone Center, date removed: _____				
	Complications: _____				
	Was the patient hospitalized post ESWL? <input type="checkbox"/> No <input type="checkbox"/> Yes				
	Admitting Diagnosis: _____				
Section C	Admission Date: _____ Discharge Date: _____				
	Procedures: _____				
	Is the patient stone free as a result of the (post ESWL) procedure(s) while hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Section D	Chemical Analysis of Fragments-Stone Composition: _____				
<input type="checkbox"/> Not Done <input type="checkbox"/> Pending					
Section E	Treatment given to prevent stones (check those that apply):		<input type="checkbox"/> Patient refuses	<input type="checkbox"/> None	
	<input type="checkbox"/> Fluid Management	<input type="checkbox"/> Diet Management	<input type="checkbox"/> Drug Management	<input type="checkbox"/> Surgical Management	
Section F	Results of Metabolic Workup (check those that apply):				
	<input type="checkbox"/> Not Done	<input type="checkbox"/> Normal	<input type="checkbox"/> Cystinuria	<input type="checkbox"/> Hyperparathyroid	<input type="checkbox"/> High Calcium
	<input type="checkbox"/> High Oxalate	<input type="checkbox"/> Low Citrate	<input type="checkbox"/> High Uric Acid	<input type="checkbox"/> Low Volume	<input type="checkbox"/> Pending
	<input type="checkbox"/> Other: _____				
Section G	Please indicate the date of the next follow up visit: _____				
	Is the patient symptomatic? <input type="checkbox"/> No <input type="checkbox"/> Yes				
	Does the patient need re-evaluation by the Kidney Stone Center? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please send films and a new X-ray Evaluation Form)				
	If the patient has not had follow up, reason(s): _____				
	Your office is requested to contact the patient and arrange for follow up. Date: _____				
	Method of contact: _____ Response: _____				
Were any problems encountered with this referral?					

PLEASE MAIL COMPLETED FORM TO: KIDNEY STONE CENTER, 1719 E. 19TH AVE, #172, DENVER, CO 80218.