

Please ensure that all sections are completed *(please tick as appropriate)*

Patient Information

Surname:.....

First name:.....

TLOC number:.....

Date of birth: / /

Telephone:.....

Male: Female:

Treatment Required:

Please discuss the following contraindications with the patient

Antiplatelet therapy Yes No

Clotting disorders Yes No

Pregnancy Yes No

Steroid injection in the past 12 weeks Yes No

NSAIDS in the past 2 weeks Yes No

Cardiac Pacemaker/Device Yes No

Infection to treatment site Yes No

History of tendon/ligament damage Yes No

History of Bone Cancer Yes No

Patient Consent signed Yes No

Relevant Details (please detail below):

Diagnosis

Insertional Achilles tendinopathy

Plantar fasciitis

Subacromial pain syndrome

Calcific tendinitis of the shoulder

Tennis elbow/Golfer's elbow

Greater trochanteric pain syndrome

Patella tip syndrome

Osgood-Schlatter disease

Medial tibial stress syndrome

Other (please detail below):

Does the patient wish to be enrolled on the TLOC outcomes study?

Yes No

Patient Information Leaflet provided?

Yes No

Signed by:

I confirm I have discussed the proposed treatment and contraindications with the patient:

Referrer's name and address or stamp

Contact number: