DR. BEN DUKE **DR. JOSEPH ARME**

TRT Treatment Patient Info

(Patients, please complete top section only)

Patient's Name: _____ _____ _____ _____

(First name) (M.I) (Last name) (Suffix)

Birth Date: _____ **Age:** _____ **Sex:** ☐M ☐F **SS#:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email Addresses: (H): _____ (W): _____

Phone #'s: (H): _____ (C): _____ (W): _____

Preferred type of contact: □ Home Email □ Work Email □ Home Address □ Home Phone □ Cell Phone □ Work Phone

Emergency Contact: _____ Relationship: _____ P: _____

Employment Status: □ Full-time □ Part-time □ Student □ Homemaker □ Unemployed □ Retired

Occupation: _____ **Employer:** _____

Job Requirements: □ Sit □ Stand □ Bend □ Lift □ Carry □ Travel □ Other: _____

Whom may we thank for referring you? □ Google □ Facebook □ Person: _____ □ Other: _____

Thank you, please return this form to the receptionist!!!

TRT Provider Initial Treatment Form

Complaints & Functional Assessment Pre-Treatment:

Patient's subjective and objective data reviewed, and primary areas being considered for treatment are:

1. _____ VAS (_____/10)
2. _____ VAS (_____/10)
3. _____ VAS (_____/10)

Goals & Desired Functional Improvement Post-Treatment:

1. _____
2. _____
3. _____

ICD-10 Diagnosis: 1. _____ 2. _____ 3. _____ 4._____ 5._____ 6._____

3123 Southgate Cir, Sarasota, FL 34239 | Phone (941) 366-0203 | Fax (941) 366-0204
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Extracorporeal Shockwave Therapy Patient Consent Form

Suitability for ESWT (Extracorporeal Shockwave Therapy) also known as TRT and nicknamed "the stem cell machine" from the TV show The Doctors.

By answering the following questions, you will assist us in deciding if you are suitable for ESWT.

- Do you have bleeding disorder / tendency? Yes / No
- Are you on NSAIDS or anti-coagulant treatment? Yes / No
- Have you been injected with cortisone this month? Yes / No
- Are you using a cardiac pacemaker? Yes / No
- Do you have cancer / tumor? Yes / No
- Do you have a tear in the tendon? Yes / No
- Do you have skin infection? Yes / No
- Are you pregnant? Yes / No

RISKS OF THIS PROCEDURE

a) Petechiae or mild bruising. This usually subsides without treatment.
b) Pain and soreness. This is temporary and resolves after a week.
c) Tendon rupture and nerve injury. This is avoided by using treatment with lower energy levels and avoiding the nerve.

Consent for Procedure:

I, _____, The Undersigned, do hereby consent to authorize the application of Extracorporeal Shockwave Therapy (ESWT) for my condition of _____. I have been fully informed of focal ESWT which use has been fully explained to me by my treating physician/staff, and I fully understand the nature of this treatment. I also confirmed that I have been given the opportunity to discuss and clarify any concerns and that no guarantees have been made to me as to the result/outcome of the treatment.
I have been advised that the treatment with ESWT will be mostly for pain relief and may offer an improvement of function. I also understand foregoing treatment is not the first option for my condition and an alternate treatment has either already been provided or offered to me.

Patient or Guardian Signature: _____ Date: _____

Staff Witness Signature: _____ Date: _____

Staff Witness (Print Name): _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the boxes below, I authorize being contacted for practice reminders by:

Mail □

Email □ Email address: _____

Phone □ Phone Number(s): _____

Voicemail □

By checking the boxes below, I authorize being contacted for birthday greetings or promotions about the practice by:

Mail □

Email □ Email address: _____

Phone □ Phone Number(s): _____

Voicemail □

By checking the line below, I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____

Patient Name (please print) Date

_____

Signature of Patient, Parent, Guardian, or Patient's legal representative

_____

Name of Parent, Guardian or Patient's legal representative

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____ _____

_____ _____

_____ _____

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