Michael O'Neill Fc.Pod(Surg)
Consultant Podiatric Surgeon

Extra-Corporeal Shockwave Therapy Consent Form

Patient Surname		Patient First Name	
Patient's address			
Date of Birth	……/……./……..	Hospital Number	

Presenting Symptoms	**Achilles Tendinopathy**	
	Plantar Fasciitis	
Shockwave Intensity		Bar
Number of Shocks		@ Hz
Number of Sessions Planned	**1 2 3 4 5 6**	

The risks associated with ECSWT include: Pain during and after treatment; swelling, reddening and bruising in the area being treated as well as some tingling.

The purpose of ECSWT is to create an inflammatory response therefore it is ESSENTIAL that you do not take any anti-inflammatory pain killers during the course of the treatment such as *Ibuprofen, Voltarol or Naproxen.* If you are taking any pain killers please check with your podiatrist first whether they will counteract your treatment. Failure to do this could cause a failure of resolution or a prolonged treatment time.

The above information has been explained by Michael O'Neill, Consultant Podiatric Surgeon.			
		Michael O'Neill	
		Date	……/……/……..
*To be completed by the **patient**, or the **patient's parent / guardian** if under 16 (delete parts **in bold** as appropriate)*			
By signing below you confirm that you have read the above. You also agree that the procedure has been satisfactorily explained to you and that you wish to go ahead with the procedure. If you have any concerns about aspects not covered above please raise this with your podiatrist before you sign below.			
Signed		Name (Printed)	
		Date	……/……/……..

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Patient Outcome Measures Form: ***PRE-TREATMENT***

Patient Surname		Patient First Name	
Patient's address			
Date of Birth	……/……./……..	Hospital Number	

Circle which foot is to be treated:	**Right**	**Left**	**Both**
Out of 10, how bad is the pain?	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹		
How long have you had the pain for?		Today's Date	

During the past four weeks how frequently, as a result of your foot or ankle, have you:	Not at all	Rarely	Some of the time	Most of the time	All the time
Had pain in your foot / ankle					
Avoided walking long distances					
Changed the way you walk due to pain					
Walked slowly due to pain					
Had to stop and rest because of pain					
Avoided some hard or rough surfaces due to pain					
Avoided standing for long periods of time because of pain					
Caught the bus or used the car instead of walking because of pain					
Felt self conscious about your foot / ankle					
Felt self conscious of the shoes you have to wear					
Had pain which is worse in the evening					
Had shooting pains in your foot / ankle					
Had pain that prevents you from carrying out work and everyday activities					
Had pain that prevented you from taking part in social / recreational activities					
How would you describe the pain that you usually have?	None	Very mild	Mild	Moderate	Severe
Have you been troubled by your foot/ankle in bed at night?	None	1 - 2 nights	Some nights	Most nights	Every night
Completed with the help of a practitioner?	**YES**			**NO**	

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Extra-Corporeal Shockwave Therapy Treatment Form

Treatment for:		Plantar Fasciitis Achilles Tendinopathy		
Treatment Number	**Shockwave Intensity**	**Number of Shockwaves**	**Frequency**	**Signed**
1	Bar		Hz	Michael O'Neill
2	Bar		Hz	Michael O'Neill
3	Bar		Hz	Michael O'Neill
4	Bar		Hz	Michael O'Neill
5	Bar		Hz	Michael O'Neill
6	Bar		Hz	Michael O'Neill

Notes about treatments

Michael O'Neill Fc.Pod(Surg)

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Patient Outcome Measures Form: ***POST-TREATMENT***

Patient Surname		Patient First Name	
Patient's address			
Date of Birth	……/……./……..	Hospital Number	

Circle which foot was treated:	**Right**	**Left**	**Both**
Out of 10, how bad is the pain?	☺ 0 1 2 3 4 5 6 7 8 9 10 ☹		
Today's Date			

During the past four weeks how frequently, as a result of your foot or ankle, have you:	Not at all	Rarely	Some of the time	Most of the time	All the time
Had pain in your foot / ankle					
Avoided walking long distances					
Changed the way you walk due to pain					
Walked slowly due to pain					
Had to stop and rest because of pain					
Avoided some hard or rough surfaces due to pain					
Avoided standing for long periods of time because of pain					
Caught the bus or used the car instead of walking because of pain					
Felt self conscious about your foot / ankle					
Felt self conscious of the shoes you have to wear					
Had pain which is worse in the evening					
Had shooting pains in your foot / ankle					
Had pain that prevents you from carrying out work and everyday activities					
Had pain that prevented you from taking part in social / recreational activities					
How would you describe the pain that you usually have?	None	Very mild	Mild	Moderate	Severe
Have you been troubled by your foot/ankle in bed at night?	None	1 - 2 nights	Some nights	Most nights	Every night
Completed with the help of a practitioner?	**YES**			**NO**	