Please complete for Dorset registered patients, who are newly diagnosed as having osteoporosis or are a fragility fracture risk patient.
GP referrals only accepted on this form for new patients, any patients previously accessing a similar service at DCHFT, will not be accepted and this request form will be returned to you.

Note: As a Referrer, under the Ionising Radiation Medical Exposure Regulations 2000 (IRMER), YOU are responsible for providing sufficient information to allow for identification of the patient and justification of the examination. If you do not do this, the request form will be returned to you.

NUFFIELD BOURNEMOUTH HOSPITAL - **DEXA REQUEST FORM**

Surname: <Patient name> **<Patient name>**	Date of birth: **<Date of birth>** **NHS no <NHS number>**	Consultant:	Extra copy to:	Date received:
First name(s): **<Patient name>**	Pt Mobility: Able to transfer independently/with minimal assistance? Y / N	This MUST be completed for all females of child- bearing age (menstruating) PREGNANCY STATUS *Delete as applicable*		Appt date:
Address: **<Patient address>**	Transport required? Y / N ☐ Car ☐ Sitting ambulance ☐ With carer	PREGNANT NOT PREGNANT BREAST FEEDING		Appt time:
Tel no: **<Patient contact details>**	Pt Weight: <160kg/350lbs? Y / N	First day of last period:	ID check (name, address, DOB):	
GP: **<GP name>**	Practice:	Age at menopause:	This examination has been justified & authorised by:	

CLINICAL INDICATION FOR DEXA SCAN

1. Patients aged under 40 years: refer to……, Consultant Rheumatologist identifying indication for scan

2. Patients aged 40-60 years MUST have one or more of the following risk factors:

☐ Low trauma fracture since age 50 *(Identify site)*

☐ Long-term oral corticosteroids (>3 months)	☐ Vertebral fracture on x-ray *(Attach copy of report)*
☐ Osteopaenic x-ray *(Attach copy of report)*	☐ Malabsorption disorder *(i.e. Coeliac, Colitis, Crohn's)*
☐ Male hypogonadism	☐ Chronic liver disease / alcoholism
☐ Patient for hip resurfacing	☐ Chronic respiratory disease with long-term, regular, inhaled steroids

☐ Other condition associated with osteoporosis *(Circle as applicable)*
Chronic renal disease / Hyperthyroidism / Hyperparathyroidism / Cushing's syndrome / Long-term treatment with anti-epileptics / Long-term treatment wit oestrogen suppressive therapy (E.g Depo-Provera, aromatase inhibitors) / Rheumatoid arthritis / Ankylosing Spondylitis

3. Patients older than 60 years, any of the above risk factors AND/OR any of the following risk factors:

☐ Recent onset vertebral kyphosis/loss of =/>3" in height *(Attach copy of lateral spine x-ray report)*	☐ Female with maternal history of hip #	☐ Low BMI (<19)

☐ Prior history of untreated oestrogen deficiency (Premature menopause - natural/surgical <age 45) or amenorrhoea >12 months

4. Current osteoporosis treatment (specify duration):

☐ Alendronate	☐ Etidronate	☐ Ibandronate	☐ Risedronate	☐ Calcium & vit D
☐ Raloxifene	☐ HRT	☐ Testosterone	☐ Strontium Ranelate	☐ Calcitonin / ☐ Parathyroid hormone

4. Additional information / Other medication

Referrer's Signature	Referrer's Name: *(Pls print clearly)*	Date:**<Todays date>**