DEXA - Imaging referral form for NHS patients

Please complete, seal in an envelope marked as confidential, and return to:
DEXA Service, Radiology Dept, 1st Floor Trelawny Wing, Truro. TR1 3LJ

Patient Details	
Patient name:	**Address:**
Date of birth:	**NHS number:**

Clinical history:

Reason for Referral:

Risk Factors (Y/N)					
Previous low trauma fracture >50		Low BMI (>21)		Excess alcohol >= 4 units per day	
Previous vertebral fracture		Secondary Osteoporosis		Rheumatoid arthritis	
Parental hip fracture		Oral Corticosteroids > 3 months		Smoker	

	Y / N	Further information
Has the patient been diagnosed with premature untreated oestrogen deficiency? (primary hypogonadism, menopause / hysterectomy <45, pre-menopausal amenorrhoea >6 months)		
Has the patient been diagnosed with any predisposing factors? (malabsorption, inflammatory bowel disease, liver disease, endocrine disorders, transplantation, previous anorexia, prolonged immobility, AI treatment, ADT treatment etc)		
Has the patient experienced any falls in the last 12 months?		

Please turn over

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	Y / N	Further information
Is a lateral scan required for looking for vertebral collapse due to height loss of 5cm or more, kyphosis, and/or sudden unexplained back pain?		
What is their current medication?		
Is the patient currently, or have they ever received treatment for osteoporosis		
Has the patient had any previous DEXA scans?		When: Where:
Can the patient get onto a couch and lie flat for 10-15 mins unaided?		If **no** please contact the Bone Density Scanning Department on ext: 3361 to discuss prior to making an appointment.
Specific Instruction / Particular patients needs?		

Imaging requested
Procedure to be performed

Requesting Clinician
Print name:
Professional registration number:
Referring practice:
Date of request:
Signature: