ADULT BONE DENSITOMETRY REQUEST FORM

To make an appointment please **SEND** this **COMPLETED** card to:

TEL: 020 8725 2657
EMAIL: stgh-tr.SGHdexascans@nhs.net

Surname: Hospital No.:

First Name: D.O.B:

Sex:

Patient Address:

Tel No.:

Transport Required? YES/NO

Private Patient? YES/NO

Patient Pregnant? YES/NO

REFERRING CLINICIAN:
(please print)

Ward/Clinic/Surgery:

Date: **SIGNATURE:**

GP Address:

Tel No.:

PLEASE ENSURE THAT BOTH PARTS ARE COMPLETED FULLY

INDICATION FOR REFERRAL

Please tick below as appropriate

PRIMARY PREVENTION:

- ☐ Untreated early menopause (age <45 years)
- ☐ Low BMI (<19kg/m2, anorexia)
- ☐ Untreated hypogonadism in men
- ☐ Aromatase inhibitor treatment
- ☐ Prostate cancer with anti-androgen therapy
- ☐ Primary Hyperparathyroidism / Cushing's Syndrome
- ☐ Thyrotoxicosis
- ☐ Growth hormone treatment
- ☐ High alcohol intake
- ☐ Liver disease (e.g. Primary Biliary Cirrhosis)
- ☐ Malabsorption
- ☐ Oral steroid treatment (daily for >3 months)
- ☐ Inflammatory arthropathies
- ☐ Kidney dialysis
- ☐ Transplant assessment
- ☐ Prolonged Immobility (>6 months bed ridden)
- ☐ Family History (first degree relative with osteoporosis)

SECONDARY PREVENTION:

- ☐ Follow up scan (usually no sooner than 2-5 years)
- ☐ Height Loss/Kyphosis (>3 cm)
- ☐ Vertebral fracture
- ☐ Low trauma fracture (e.g. fall from standing position, excluding fingers and toes)
- ☐ Radiological evidence of osteopenia

❖ Please provide any additional information that you feel would be useful to us i.e. any learning or physical difficulties, other medical conditions

TO ENABLE US TO PERFORM THE SCAN YOUR PATIENT MUST:

1) BE ABLE TO WALK UNAIDED **2) LIE FLAT** **3) WEIGH UNDER 20 STONE/125 KG**

PLEASE INFORM US IF YOUR PATIENT HAS HAD A BARIUM MEAL/CT SCAN OR MRI SCAN WITHIN THE LAST 3 WEEKS

NB THERE MUST BE SUFFICIENT INFORMATION PROVIDED FOR THE OSTEOPOROSIS UNIT TO BE ABLE TO JUSTIFY THE REQUEST UNDER THE IONISING RADIATION (MEDICAL EXPOSURE) REGULATIONS 2000