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| --- | --- |
| **InHealth Logo (Smaller).jpg** | **C:\Documents and Settings\Christina.Fromont\Local Settings\Temporary Internet Files\Content.Outlook\GQ7NC0YS\foiextract20111202-25135-ebzj6n-0-1_31.jpg** |

**DXA REFERRAL FORM**

**Please note – we are unable to accept referrals for patients under 18 years of age**

|  |  |
| --- | --- |
| **PATIENT** | **REFERRER** |
| NHS Number |       | Name |       |
| Forename |       | GMC/HPC/NMC No |       |
| Surname |       | Address |       |
| Address |       |  |  |
| Date of Birth |       | Referring PCT Code |       |
| Telephone (Home) |       | Referring Practice Code |       |
| Telephone (Work) |       | Telephone No. (**for urgent clinical findings)** |       |
| Telephone (Mobile) |       | Fax No. |       |
| E-mail Address |       | NHS.net mail only |       |
| Gender | Male [ ]  Female [ ]  | Eligible for and does require NHS funded transport? **(car transport only)** Yes[ ]  |
| Physical/Communication difficulties (specify if any): | Wheelchair user? Yes [ ]  |
| If interpreter required, language:       | The patient must be ambulant, or if a wheelchair user they must be able to transfer independently onto the examination couch. |
| Ethnicity      |  |
| **Clinical Indication/ Problem** Please indicate which of these risk factors apply to the patient: |
| Recent fracture of wrist, humerus or spine | **[ ]**  | Long term use of steroids or thyroxine | **[ ]**  |
| Parental hip fracture | **[ ]**  | Low body mass (BMI less than 19) | **[ ]**  |
| Radiological osteopenia | **[ ]**  | Coeliac disease | **[ ]**  |
| Inactive Lifestyle | **[ ]**  | Chronic liver disease | **[ ]**  |
| Smoking | **[ ]**  | Type 1 diabetes | **[ ]**  |
| High alcohol intake | **[ ]**  | Rheumatoid arthritis | **[ ]**  |
| Early menopause (<45 years) | **[ ]**  | Hypoparathyroid / hyperthyroid disease | **[ ]**  |
| Other (please specify):       |
| **Has the patient previously had a DXA scan? Yes** **[ ]  No** **[ ]** **If yes, what date was the scan?** **Is your patient on bone sparing treatment? Yes [ ]  No [ ]** *(Note to triage, if this answer is yes then axial scan only)* |
| **Notes:*** A DXA scan should only be repeated every 18 months – 2 years
* This scan is of limited value in a patient whose weight is over 150kg
 |
| Referrer’s Signature       Date of referral       |
| **Please post, fax or e-mail this form to the InHealth Patient Referral Centre:****Sandbrook House, Sandbrook Way, Rochdale OL11 1RY****Tel: 0844 581 0301 Fax: 0844 581 0305 E-mail: INL.inhealthreferrals@nhs.net** | **www.inhealthgroup.com****Version: March 2012** |