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| |  |  | | --- | --- | | **InHealth Logo (Smaller).jpg** | **C:\Documents and Settings\Christina.Fromont\Local Settings\Temporary Internet Files\Content.Outlook\GQ7NC0YS\NHS Southampton City Logo.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 CCG 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 (less than 19 bmi) | | |  |
| 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?** | | | | | | | |
| **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 attach to the NHS e--referral system**  **InHealth Referral Centre**  **Tel: 0333 202 0297** | | | | | | **www.inhealthgroup.com**  **Version: September 2018** | |