

DXA REQUEST FORM

PLEASE NOTE - WE ARE UNABLE TO ACCEPT REFERRALS FOR PATIENTS UNDER 18 YEARS OF AGE

<p>Patient ID</p> <p>NHS Number _____</p> <p>First Name _____</p> <p>Surname _____</p> <p>Address _____</p> <p>_____</p> <p>_____ Post Code _____</p> <p>Date of Birth _____</p> <p>Telephone (Home) _____</p> <p>Telephone (Work) _____</p> <p>Telephone (Mobile) _____</p> <p>Email Address _____</p> <p>Gender Male <input type="checkbox"/> Female <input type="checkbox"/></p>	<p>Referring Clinician</p> <p>Name _____</p> <p>GMC/HPC/NMC No. _____</p> <p>Address _____</p> <p>_____</p> <p>_____ Post Code _____</p> <p>Referring PCT Code _____</p> <p>Referring Practice Code _____</p> <p>Telephone No. (For urgent clinical findings) _____</p> <p>Fax No. _____</p> <p>NHS Mail (nhs.net only) _____</p>		
<p>Physical/Communication difficulties (Specify if any) _____</p> <p>_____</p> <p>If interpreter required, language _____</p> <p>Religion _____</p> <p>Ethnicity _____</p>	<p>Eligible for NHS Funded Transport Yes <input type="checkbox"/></p> <p>Car Transport Required Yes <input type="checkbox"/></p> <p>Wheelchair User Yes <input type="checkbox"/></p> <p>The patient must be ambulant, or if a wheelchair user they must be able to transfer independently on to the scanner or examination couch.</p>		
<p>Clinical Indication/Problem</p> <p>Please provide as much relevant clinical information to ensure the most appropriate investigation is performed.</p> <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> History of prior fragility fracture of wrist or humerus <input type="checkbox"/> Parental hip fracture <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Coeliac disease </td> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> Drug medication <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol use <input type="checkbox"/> Inactive lifestyle/Poor Diet <input type="checkbox"/> Other _____ </td> </tr> </table> <p>Has the patient previously had a DXA scan? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, what date was the scan? ___/___/___</p> <p>What were the scan findings? _____</p> <p>_____</p> <p>_____</p> <p>Allergies (specify, if any):</p>		<input type="checkbox"/> History of prior fragility fracture of wrist or humerus <input type="checkbox"/> Parental hip fracture <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Coeliac disease	<input type="checkbox"/> Drug medication <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol use <input type="checkbox"/> Inactive lifestyle/Poor Diet <input type="checkbox"/> Other _____
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<p>The scan carried out will be of the spine and proximal femur - please confirm that the patient:</p> <p>Has not had a recent barium or radio-nuclide study <input type="checkbox"/></p> <p>Has not had a radio-opaque implant in the area of measurement <input type="checkbox"/></p> <p>Does not have severe arthritic or fracture deformity of the spine or femur <input type="checkbox"/></p> <p>NB Any of the above is a contraindication to a DXA scan</p>			
<p>For X-Ray examinations of females of child-bearing capacity, is there any possibility of the patient being pregnant?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="text-align: right;">Date of last menstrual period ___/___/___</p>			
<p>Referrer's Signature _____ Date of request ___/___/___</p>			