OSTEOPOROSIS SERVICE DXA REQUEST FORM
Swansea Bay University Health Board, Nuclear Medicine Department,
Singleton Hospital, Swansea SA2 8QA Tel: 01792 285295
Email: SBU.NuclearMedicinePatientBookings@wales.nhs.uk

To be completed by entitled referrers only

Full Name: Address:	Date of Birth: F [ ] M [ ] Tel No: NHS/Hospital No: Height (cm): Weight (kg): GP Practice Name: GP Address:

Please tick relevant box or boxes and add additional comments below as appropriate

[ ] Radiographic evidence of osteopenia/osteoporosis

[ ] Evidence of vertebral fracture on x-ray, CT, MRI and bone scintigraphy

[ ] Height loss. **Please quantify.**

[ ] Previous low trauma fracture especially of the hip, spine or wrist, proximal humerus, rib, distal femur, pubic rami. **Please state location of fracture**.

[ ] Current osteoporosis treatment
[ ] Commencing corticosteroid therapy
[ ] Corticosteroid therapy for more than 3 months
[ ] Aromatase inhibitor therapy
[ ] Androgen deprivation

[ ] Premature menopause (age <45 years)
[ ] Hypogonadism
[ ] Prolonged secondary amenorrhoea (>1 year)
[ ] Post-menopausal
[ ] Rheumatoid arthritis
[ ] Anorexia/bulimia
[ ] Smoking **Please quantify.**

[ ] Colitis/coeliac disease/gastrointestinal disease/malabsorption/parenteral nutrition
[ ] Transplant
[ ] Diabetes [ ] Type 1 [ ] Type 2
[ ] Chronic Obstructive Pulmonary Disease (COPD)
[ ] Primary hyperparathyroidism
[ ] Hyperthyroidism [ ] Hypothyroidism
[ ] Vitamin D deficiency
[ ] Cushing's Syndrome
[ ] Chronic renal failure/dialysis
[ ] Three or more daily units of alcohol intake
[ ] Cirrhosis/liver disease
[ ] Prolonged immobilisation
[ ] Family history of osteoporosis
[ ] Parental history of hip fracture
[ ] Intermediate / high risk from FRAX without BMD
[ ] Falls (NOGG guidelines)
[ ] Low Body Mass Index (<19kg/m^2)
[ ] Osteogenesis imperfecta [ ] BMAD scores required
[ ] Monitoring change in bone density **Specify hospital and date of previous scan**.

[ ] Other reason for referral - *please detail any current bone protection, duration of treatment, treatment intolerances. If previous cancer, please provide type and date of diagnosis.*

Additional Details – Please Quantify (Mandatory Field)

[ ] **FRAX without BMD:** ___% (Major Fracture) __% (Hip Fracture) (https://www.sheffield.ac.uk/FRAX/tool.aspx?country=1)
[ ] **Frailty Score:**

Name of Referrer: Designation: Date:	Referrer Signature:

For Nuclear Medicine use only:

Appointment Date:	Authorised by:
Radis No: ABM	Authorisation Date:
Procedure Details	**Pregnancy** (Female patients age 12-55yrs only) *Is patient pregnant?*
Patient ID checked by:	
Exposure performed by:	[ ] **Yes** [ ] exam is authorised Practitioner authorising exposure:_____ [ ] exam is deferred
Total No. DXA scans performed:	[ ] **Unsure** LMP: dd / mm / yy [ ] LMP not overdue, proceed with DXA exam [ ] Referrer contacted, exam deferred [ ] Referrer contacted, exam urgent, Practitioner authorising exposure:_____
Total DAP delivered: cGy.cm^2	[ ] **No** proceed with exam
Other relevant details:	*I confirm that the above information is correct;* Patient Signature:
	Pregnancy Checked by: