

**FAO Mrs Pat Taylor**

**Osteoporosis Centre, C level, West Wing, MP77**

**Southampton General Hospital**

**Southampton**

**SO16 6YD**

**Telephone 023 8120 4696**

**Fax 023 8120 8995**

**Direct access referral for DXA scan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referring GP name:** |  | **Date of referral:** |  |
| **Patient name:** | | **Hospital number:** | |
| **Date of birth:** | | **NHS number:** | |
| **Sex:** | | **Registered GP name:** | |
| **Patient address:** | | **Surgery address:** | |
| **Phone (home):** | | **Surgery phone:** | |
| **Phone (work):** | | **Surgery fax:** | |
| **Signature of referring clinician:** | | **Surgery email:** | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Previous scan here** (please circle) | **Yes** | **No** | | **Unsure** |
| **May require hoist to transfer** (please circle) | **Yes** | | **No** | |
| **Interpreter required** (please circle)  If ‘yes’ please specify | **Yes** | | **No** | |
|  | | | |

**Please indicate reason for referral**

|  |  |
| --- | --- |
| **Low impact fracture** |  |
| **Radiographic osteopenia** |  |
| **Corticosteroid therapy** (current or planned for 3 months or longer) |  |
| **Evidence of strong risk factors** (please specify) |  |
| **Repeat scan** |  |

**Please record any relevant information (eg fracture history, current drugs etc.)**

**.........................................................................................................................................................**

**.........................................................................................................................................................**

**.........................................................................................................................................................**