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| **SHFT DEXA Scan Request Form**  [radoffice@southernhealth.nhs.uk](mailto:radoffice@southernhealth.nhs.uk) | | | NHS | Private |  |
| **Name Title: NHS Number:**  **Address DOB:** | | | | | Appt date: Time: |
| **Walking**  **Transport**  **Hoist**  **Trolley** |
| **Consultant / GP** | **PREGNANCY STATUS**  **Possibility of pregnancy?**  Y  / N  **Comment:**  **LMP**: | | | | **FOR RADIOLOGY USE ONLY:**  **JUSTIFIED** Yes / No :-  **IRMER Practitioner: ………………………**   Consultant / SPR / Radiographer / Asst Practitioner **OPERATOR CHECKS:**  **ID code : …………………**  **PREGNANT:**  **Y / N / N/A**  **Comments:**  **Initials: …………..** |
| Surgery |
| **INCOMPLETE / ILLEGIBLE FORMS WILL BE RETURNED** | | | | |
| **1. Patients under 40 years or not fitting criteria below, please or**  **discuss with a Radiologist** | | | | |
| **2. Patients older than 40 years, BMD recommended by FRAX** | | | | |
| **3. Patients aged 40-60 years with one of the following risk factors:**  Long term oral corticosteroids Chronic respiratory disease Thyrotoxicosis  (more than 3 months)    Vertebral fracture on x-ray Rheumatoid arthritis  Hyperparathyroidism  **Please send copy of report**  Osteopenic x-ray  Malabsorption disorder  Aromatase inhibitor  **Please send copy of report** (i.e. coeliac, colitis, liver disease)    Androgen deprivation therapy  Immobility/paraplegia  Male hypogonadism  Specify cause:  and duration: | | | | |
| **4. Patients older than 50 years with a low trauma fracture**  **(excluding fractures of tarsals, metatarsals, carpals or metacarpals):**  Specify site:       and date of fracture: | | | | | |
| **5. Patients older than 60 years must have a risk factor from either the list above or the list below:**  Parental hip fracture  Recent onset thoracic kyphosis  Premature menopause  Recurrent falls (4+ during the last year )  Low BMI (<19) (natural/surgical onset < age 45) | | | | | |
| **6. Please identify current osteoporosis drug treatment: -**  Alendronate  HRT  Strontium ranelate  Alendronic acid  Ibandronate  Testosterone  Calcium  Vitamin D  Raloxifene  Etidronate  Risedronate | | | | | |
| **7. Prior DXA scan? Yes / NO If yes, where was this and when:** | | | | | |
| **Signature: Authorised Referrer IR(ME)R 2000** | | **Name (Printed):** | | | |
| **Job title:** | | **Bleep /contact number: DATE:** | | | |