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| **SHFT DEXA Scan Request Form**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:**  |