DXA Body Composition Referral Request

The Welsh Institute of Chiropractic (WIOC), University of South Wales, Treforest, Pontypridd, Rhondda Cynon Taff, CF37 1DL

Tel: 01443 483555 Fax: 01443 654142

Please complete ALL sections of this form.

Patient Name:		**M / F**
Address, inc postcode:		
DOB:		
Telephone No:		

Reason for Referral/ Clinical Justification

You are legally obliged under the Ionising Radiation (Medical Exposure) Regulations (2000) to supply sufficient clinical data to justify this exposure to ionising radiation.

Refer for scan ONLY if result may change the management of your patient.

Please tick relevant box and add comments as appropriate		**Comments**	
Patient living with HIV, to assess fat distribution in those using anti-retroviral agents associated with a risk of lipoatrophy.			
Obese patient undergoing bariatric surgery (or medical, diet or weight loss regimen with anticipated large weight loss) to assess fat and lean mass changes when weight loss exceeds approx 10%.		Please provide current weight:	
Patient requiring visceral adipose tissue (VAT) measurement to assess cardiovascular risk.		Please provide current weight:	
Patient with muscle weakness or poor physical functioning to assess fat and lean mass.			
Subject participating in an agreed ethically-approved research programme.		Research Prog Name:	
		Research Prog Number:	

Referring Clinician:	**Signature:**	**Date:**
Designation: GP / Chiropractor / Other (Please Specify)…………………………………………..		

Report to be sent to: (Please include name, full address, postcode and fax number)

FOR DEPARTMENT USE ONLY

Authorised By	Signature	Date
Practitioner		
Operator		

I have confirmed the patient's ID (name, address, DOB)	Signed:

Pregnancy Status (To be completed for all females aged 12-55yrs)		
Is the patient pregnant? Y / N	Asked By:	Date:
If Yes, scan justified? Y / N / NA	Practitioner:	Date:

Height:	Weight:	BMI:

DAP = __________________ cGy*cm^2

PATIENT CONSENT

I confirm that the procedure, its risks and benefits have been clearly explained to me, and that I give my consent to the stated procedure. I give consent for my health information to be used anonymously for research and teaching purposes.	
Signed	**Date**