**Bone Densitometry Referral Request**

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| The Welsh Institute of Chiropractic (WIOC), University of South Wales, Treforest, Pontypridd, Rhondda Cynon Taff, CF37 1DL**Tel: 01443 483555**  |

**Please complete ALL sections of this form.**

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

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| **Reason for Referral/ Clinical Justification***You are legally obliged under the Ionising Radiation (Medical Exposure) Regulations (2017) 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** |
| Vertebral fracture on X-ray/Colles fracture/low trauma fracture |  |  |
| First degree relative with low trauma fracture (wrist, lumbar spine or hip) |  |  |
| First degree relative with osteoporosis (T-score < -2.5) |  |  |
| Long term corticosteroids(Prednisolone >5mg/day >6 months) |  |  |
| Osteopenic on X-ray |  |  |
| Transplant organ recipient |  |  |
| Alcoholism |  |  |
| Premature menopause (natural/surgical) before age 45yrs |  |  |
| Unexplained amenorrhoea >12 months |  |  |
| Chronic disorders associated with osteoporosis (e.g. Coeliac disease, anorexia nervosa) |  |  |
| Rheumatoid arthritis |  |  |
| Treated with Aromatase Inhibitors OR Androgen Deprivation Therapy |  |  |
| BMI <19kg/m2  |  |  |

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

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

**FOR DEPARTMENT USE ONLY**

|  |  |
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| **Patient ID No.** |  |

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| **Authorised By** | **Signature** | **Date** |
| Practitioner |  |  |
| Operator |  |  |

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| **I have confirmed the patient’s ID** (name, address, DOB) | Operator Signature: |
| **I have provided an explanation of the procedure (including the risks and benefits of the radiation exposure) and have obtained verbal consent to proceed.** | Operator Signature:  |

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| **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: |

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| **Scan Locations**(Please tick) | **Mode** | **Date** |
| Hip | L / R | Fast / Array |  |
| AP Lumbar Spine |  | Fast / Array |
| Other (Please specify) |  | Fast / Array |
| **Vertebrae Excluded** | L1 / L2 / L3 / L4 / None |
| **DAP = \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cGy\*cm2** |