**DXA Body Composition 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** |
| 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: |  |

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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: |

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| Height: | Weight: | BMI: |

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| **DAP = \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cGy\*cm2** |