Bone Densitometry Referral Request

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

Tel: 01443 483555 **Fax: 01443 483756**

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**
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/m^2		

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:

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*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**