**Osteoporosis Referral Form**

**All referrals to the service are received via the Electronic Referral Service (eRS) – “Rheumatology” and mark referral “Osteoporosis”**

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| **Please select the urgency of the referral** |
| Routine □ | Urgent □ |

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| **PATIENT NAME, ADDRESS AND TELEPHONE NO.** | **DATE OF BIRTH** | **NHS NO.** | **CURRENT DIAGNOSES** |
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| **Reason for referral:** |

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| **Patients with the following criteria are suitable for referral to the osteoporosis clinic.** **Please select as appropriate. (Please tick)** |
| Patients intolerant of oral treatment (bisphosphonates), for consideration of alternatives □ Patients with poor renal function unable to receive bisphosphonates □Younger patients, or those with complex comorbidities □ Patients in whom a DXA scan is felt to be indicated, but who do not meet our DXA referral criteria □Patients with an eating disorder requiring a DXA scan □ |

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| Relevant family history |  |

*Please include past medical history and a medication list in referral.*

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| **REFERRING GP’s NAME** | **SURGERY DETAILS**  | **DATE OF REFERRAL** |
|  |  |  |
| **GMC registration number** |  |