**Direct access referral for DXA scan**

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| **Referring GP:** |  | **Date of Referral:** |  |
| **Patient Name:** |  | **Date of Birth:** |  |
| **NHS number:** |  | **Sex:** |  |
| **Patient Address:** |  | **Surgery Name & Address:** |  |
| **Patient Phone (home):** |  | **Surgery Phone:** |   |
| **Patient Phone (mobile):** |  | **Surgery eMail:** |  |
| **Referrers Signature:** |  |

**Reason for referral**

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| --- | --- | --- | --- |
| Low impact fracture 🞏 | Radiographic Osteopenia 🞏 | History of Corticosteroid Therapy 🞏 | Recommended by FRAX 🞏 |
| Evidence of other risk factors / Any other relevant information: |
|  |

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| --- |
| *[please circle]* |
| **Previous scan at SGH:** | Yes | No | Unsure |
| **Hoist to transfer:** | Yes | No |
| **Interpreter required:** | Yes | No |
| **Language** *including BSL***:** |  |
| **Other Accessibility:** |  |