

# DEXA Screening Application and Referral Form



Your answers to this questionnaire will be kept confidential at all times and are for the purpose of determining whether you meet the criteria for a DEXA screening scan. Your answers will be studied by one of our lead clinical staff who will approve or decline your application according to clinical guidelines we are required to adhere to. Please answer every question, and if you are unsure on anything please call one of our team to help you on 020 7042 1888.

## Patient

Name		Male	Female
Date of Birth	Phone	Email	
Address			

## Your Application

### Have you experienced any of the following risk factors?

Post-Menopausal	Yes	No
Secondary amenorrhea > 1 year (absence of menopause)	Yes	No
Low body mass index	Yes	No
Broken bone after minor injury	Yes	No
Osteopenia or X-ray report of possible osteoporosis	Yes	No
Untreated premature menopause before the age of 45	Yes	No
Untreated hypogonadism	Yes	No
Do you suffer from any of the following: Chronic liver disease, hyperparathyroidism, Gastro-intestinal disease i.e. coeliac, IBD and Crohn's disease, inflammatory arthritis such as rheumatoid arthritis or ankylosing spondylitis	Yes	No
Reduced mobility due to illness such as multiple sclerosis or Parkinson's Disease	Yes	No
Oral glucocorticoid (steroids) for > 3 months	Yes	No
Drug treatment for breast or prostate cancer	Yes	No
Loss of height	Yes	No
Do you smoke more than 15 cigarettes a day?	Yes	No
Do you weigh more than 130 kg (290 lb / 20 st)? <i>Please note, due to weight restrictions on our equipment, unfortunately we are unable to scan patients weighing over 130kg.</i>	Yes	No
Do you consume more than 35 units of alcohol per week?	Yes	No
Taking the medication thyroxine	Yes	No
Monitoring osteoporosis treatment	Yes	No
Family history of osteoporosis	Yes	No

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## Your Clinical History

Please answer these questions about previous scans:

Have you had a previous DEXA?	Yes	No
Date of scan		
Where was this done? <i>If the scan wasn't done at Oryon Imaging, please bring with you a copy of your scan and results for comparison.</i>		

## Your UK GP Details

GP Name	
Practice Name	
Address	
Phone	Fax

Thank you for your time in completing this questionnaire.

Please return to Oryon Imaging in one of the following ways:

**Email to:** [imaging@oryon.co.uk](mailto:imaging@oryon.co.uk)

**Fax to:** 020 7760 6400

One of our team will be in touch to inform you whether your application has been successful.

## Office Use Only

### Referring clinician

**This application and referral form is valid only when at least one of the risk factors is present and has been approved by the Oryon Imaging Clinical team according to Oryon's DEXA self-referral policy.**

Name	Professor John Stevenson
Address for results	Royal Brompton Hospital, Sydney Street, London SW3 6NP
Specialty/Profession	Consultant metabolic physician
Reg. code (e.g. GMC)	1575361
Signature	