Self-Referred DEXA Application Form

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Your answers to this questionnaire will be kept confidential at all times and are for the purpose of determining whether you meet the criteria to self-refer for a DEXA 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)? *Please note, due to weight restrictions on our equipment, unfortunately we are unable to scan patients weighing over 130kg.*	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? *If the scan wasn't done at Oryon Imaging, please bring with you a copy of your scan and results for comparison.*	

Your 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

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

DEXA Scan approved by:	Position:	Sign:	Date: