Please note: As a Referrer, under the Ionising Radiation Medical Exposure Regulations 2017 (IRMER), you are responsible for providing sufficient information to allow for identification of the patient and justification of the examination. If you do not do this, the request form will be returned to you.

DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST - **DXA REQUEST FORM**

Surname: Mr / Mrs / Miss	Date of birth:	Consultant:	Extra copy to:	Date received:
First name(s):	Pls confirm patient is able to transfer independently or with minimal assistance on / off scanner as PAT slide / hoist facilities are not available at this site. Y / N	This MUST be completed for all females of child- bearing age (menstruating) PREGNANCY STATUS *Delete as applicable* PREGNANT NOT PREGNANT BREAST FEEDING		Appt date:
Address:				Appt time:
Tel no:	Pls confirm patient weight is <226kg / 35 stone Y / N	First day of last period:	ID check (name, address, DOB):	
GP:	Practice:	Age at menopause:	This examination has been justified & authorised by:	

1. In order for the investigation to comply with IR(ME)R, patients MUST have clinical risk factors for osteoporosis or a history of low trauma fracture: *Pls tick relevant box below*

☐ Hx of low trauma fracture(s) after age 50 *(Identify site & age)*
(A low trauma fracture is identified as a fracture sustained in a fall from a standing height or less)

☐ Long-term oral glucocorticoid treatment (>3 months)

☐ Vertebral fracture identified on plain x-ray *(Pls attach copy of report)*

☐ Crohns / UC if high risk i.e L/T corticosteroids or ≥2 of….
- Continuing active disease
- Weight loss >10%
- BMI < 20
- Age >70

☐ Coeliac disease if high risk i.e ≥2 of….
- Persisting symptoms on gluten free diet for 1 year or poor adherence
- Weight loss > 10%
- BMI <20
- Age >70

☐ Male hypogonadism

☐ Osteopaenic x-ray *(Pls attach copy of report)*

☐ Chronic, severe, respiratory disease (with long-term, inhaled steroids / frequent courses of oral steroids)

☐ Chronic liver disease / alcoholism

☐ Other condition associated with osteoporosis *(Circle as applicable)*

Chronic renal disease / Hyperthyroidism / Hyperparathyroidism / Cushing's syndrome / Long-term treatment with anti-epileptics / Long-term treatment with oestrogen suppressive therapy (e.g Depo-Provera; or aromatase inhibitors for breast cancer) / Long-term treatment with an anti-androgen for prostate cancer / Rheumatoid arthritis / Ankylosing spondylitis

Patients older than 60 years, any of the above risk factors OR one of the following risk factors:

☐ Thoracic kyphosis/ >2" height loss ***if* confirmed vert fracture on x-ray**

☐ Female with parental history of hip # (particularly <age 75)

☐ Low BMI (<19)

☐ Prior history of **untreated** oestrogen deficiency (Premature menopause - natural/surgical <age 45) or amenorrhoea >12 months

2. 10 year probability of fracture as calculated using FRAX or QFracture (%): Major # Hip

3. Repeat scan requests

☐ **Repeat scan**

Repeat scans should be performed on the same scanner as the original if at all possible. If you are referring for a repeat scan, pls attach a copy of previous scan report (if available). Otherwise, pls identify the original *Indication* for the scan, *When & Where* it was performed, the *Results*, & any subsequent *Treatment*.

Note – Repeat scans are not usually helpful for patients on treatment to tell whether the treatment is working. They can, however, be considered after the patient has been on treatment for 5 years, to determine whether it might be appropriate to stop treatment.

Repeat scan requests will not be considered unless a minimum of 2 years have elapsed since the previous scan.

4. Current osteoporosis treatment (in all cases pls specify duration):

☐ Oral bisphosphonate	☐ IV bisphosphonate	☐ Calcium & vit D	☐ Colecalciferol
☐ Denosumab (60mg/1ml)	☐ Raloxifene	☐ HRT	☐ Teriparatide

5. Additional information / Other medication (use space overleaf if necessary or attach prescription list)

Referrer's Signature:	Referrer's Name: *(Pls print clearly)*	Department: *(Hospital referrals only)*	Date:

Pls send completed forms to the Rheumatology Department, Dorset County Hospital