Austin HEALTH
Department of Molecular Imaging and Therapy

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BONE MINERAL DENSITY REFERRAL FORM

When is scan required: _____ Date of next review: _____

Patient Details

Surname _____
First name _____
Date of birth _____
Austin UR _____
Address _____
Suburb _____

Gender ☐ Male ☐ Female ☐ Other:

Patient Contact Details

Home phone number _____
Mobile phone number _____
Email address _____
Alternative contact person _____
Phone number _____

Patient status:

☐ Public ☐ DVA
☐ Private ☐ TAC
☐ Overseas patient ☐ Workcare

Referral Information

Rebatable items (please tick)

☐ Spine / hip or other fractures with minimal trauma
☐ Patient age 70 or over
☐ Osteoporosis diagnosed previously
☐ Specific treatment for osteoporosis
☐ Long term corticosteroid therapy (oral 7.5mg or inhaled >800µg/day)
☐ Malabsorption ± including subnormal level of circulatory vitamin D
☐ Diseases: *(Please tick)*
- ☐ Chronic renal disease
- ☐ Chronic liver disease
- ☐ Hyperparathyroidism
- ☐ Hyperthyroidism
- ☐ Cushings syndrome

☐ Male hypogonadism
☐ Female hypogonadism lasting more than 6 months before the age of 45

Clinical Details: _____

Patient mobility requirements:
Weight over 150kg? ☐ Requires a hoist lift? ☐

Requesting Doctor & Report Distribution

Referring Doctor _____ Provider No. _____
Mobile _____ Signature _____
Email address _____ Date _____

Preferred mechanism of electronic transfer of report: HealthLink ☐ Medinexus ☐ Other: _____

Additional copy of report to _____
Email address _____

Preferred mechanism of electronic transfer of report: HealthLink ☐ Medinexus ☐ Other:

Patients are free to take their referral to a diagnostic imaging provider of their choice. Please discuss with your doctor first.
Referral forms may be downloaded from http://www.austin.org.au or the Austin HUB (http://hub/Assets/Files/BMD_referral.pdf)