WCHI
WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

Referral to ***OSTEOPOROSIS PROGRAM*** for ***CONSULTATION***

76 Grenville St., 4th floor
Toronto, ON M5S 1B2
Tel 416 323-2663 ***Fax*** 416 323-6484

In order for us to be able to provide your patient with the best possible care, please *FAX* the following information to:
FAX 416 323-6484

REQUIRED: * **"*Referral to Osteoporosis Program for Consultation*" form completed** *AND*
* **Current (within the last year) Bone Mineral Density test results (including pictures)**
If a Bone Density test has not been performed within 12 months of the available date this form authorizes Women's College to perform a Bone Mineral Density test prior to the appointment.

If available:
* Additional previous Bone Mineral Density test results
* Thoraco-Lumbar spine and any fracture related x-ray or medical imaging results
* Recent blood work results

Pt Name: _____ DOB (dd/mm/yy): _____/_____/_____

Address: _____ Postal Code: _____

Home Tel: _____ Daytime Tel: _____ Health Card #: _____/____

Please ✔ all risk factors for Osteoporosis that apply to your patient:

- ☐ Low trauma fracture age 40+yrs_____
- ☐ Hx vertebral compression fracture
- ☐ Systemic glucocorticoid tx ≥ 3months
- ☐ Hyperparathyroidism
- ☐ Rheumatoid arthritis
- ☐ Malabsorption syndrome eg Crohn's, UC, Celiac Disease
- ☐ Hypogonadism / Prolonged amenorrhea
- ☐ Early menopause (<45 yrs of age)
- ☐ Past hx hyperthyroidism
- ☐ Chronic anticonvulsant tx
- ☐ Chronic heparin tx
- ☐ Chemotherapy (Dx _____)
- ☐ Propensity to fall
- ☐ Smoker
- ☐ Excessive alcohol intake
- ☐ Low dietary calcium intake
- ☐ Wt < 57 kg/126 lbs and/or Eating Disorder
- ☐ Wt loss >10% of wt at age 25 yrs
- ☐ Family hx osteoporotic fracture or osteoporosis
- ☐ Cannot tolerate OP medications

Other relevant health history (eg: low trauma fracture site/age, medications):

☐ Currently on medication for Osteoporosis: (Please specify) ▸

Referring Physician's Signature: **Billing #:**

Physician Name: _____ Telephone: _____

Address: _____ Fax: _____

Date of Referral: _____

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