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OSTEOPOROSIS REFERRAL FORM

URGENCY: ❑ Routine ❑ Semi-Urgent ❑ Urgent

REFERRAL DATE: ____/____/______
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: ______________________ DOB: ___/___/____
DD/MM/YYYY

Sex: ____ Email address: ______________________

Health card: ________________ Version code: ________

Full address: ______________________________

Telephone: ______________ Alternate #: ______________

❑ Patient lives in an under-serviced or remote community in Northern Ontario and therefore meets the Ontario Osteoporosis Strategy criteria for an Ontario Telemedicine Network video visit

ADDITIONAL PATIENT INFORMATION

Preferred name (*if different from above*): WCH Medical Record Number (*if known*):

Gender(*if different from above*): Pronouns: ❑ He/Him ❑ She/Her ❑ They/Them ❑ Other

Other insurance coverage (IFH, UHIP, etc.): ❑ Self-pay

Language spoken: Interpreter required: ❑ Yes ❑ No

Allergies:

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:

Billing #: ______________________

Signature: ______________________

❑ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: ______________________________
Primary Care Provider Telephone: ______________________________

REASON FOR REFERRAL

☐ New vertebral fracture (within past 24 months)

☐ New low-trauma hip fracture (within past 24 months)

☐ Current high dose systemic steroids (the equivalent of: greater than or equal to Prednisone 7.5 mg of daily for at least 3 months in the last year)

☐ Low-trauma fracture, non-vertebral/non-hip (within past 24 months)
○ Humerus ○ Wrist ○ Pelvic ○ Other:______________

☐ On high risk medication with low bone density or history of fragility fracture:
- ○ Prolonged low dose systemic steroids (the equivalent of: less than prednisone 7.5mg daily for at least 3 months in the last year)
- ○ Aromatase inhibitor
- ○ Androgen deprivation therapy
- ○ Chronic anti-seizure medication
- ○ Other: ______________________________

☐ Other risk factors/comorbidities with low bone density:
- ○ Prior fragility fractures: Site ____________ Year ____________
- ○ Inflammatory arthritis, malabsorption syndrome, parathyroid disease
- ○ High risk for falling: Reason______________________

☐ Other:______________________________
____
____

Please attach the following:

❑ Bone mineral density test results within past 24 months and any previous (including pictures)

❑ Imaging results e.g. thoraco-lumbar spine, fracture(s)

❑ Relevant consultation notes (e.g. orthopaedic, emergency room)

❑ Recent blood work results

Osteoporosis Medications:

Current Osteoporosis Medications:
☐ No ☐ Yes______________

Past Osteoporosis Medications:
☐ No ☐ Yes______________

Other Medications:

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