WCH
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street
Toronto, Ontario
M5S 1B2
Tel: 416-323-2663 Fax: 416-323-6484

OSTEOPOROSIS REFERRAL FORM

URGENCY: ☐Routine ☐Semi-Urgent ☐Urgent
REFERRAL DATE: ____/____/_____
DD / MM / YYYY

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

MRN:_____ HCN:_____
Name:_____
Sex:_____ Date of Birth:_____/_____/_____
DD / MM / YYYY
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: WCH Medical Record Number (*if known*):

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

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) — based on **spine** imaging (**NOT** chest/abdomen imaging)
☐ 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:

PERMISSION TO CONTACT

By providing the patient's email address, you are confirming that the patient has consented to receiving email communications from WCH regarding their appointment(s), patient experience surveys, enrollment in our patient portal (myHealthRecord), and other medical documentation.

Patient email address:_____

Disclaimer: All electronic communication carries some risk. Patients may withdraw their consent to receive emails from WCH or change their preferences at any time.