Osteoporosis and Bone Disease Program
268 Grosvenor St.
London, ON N6A 4V2
Phone: 519-646-6000 ext. 64424
Fax: 519-646-6043

Dr. Nadeen Al-Baz
Dr. Kristin Clemens
Dr. Tayyab Khan
Dr. Jenny Thain

Osteoporosis and Bone Disease Program Referral Form

Please review the Osteoporosis Clinical Practice Guidelines to assist with your clinical decision making:

- *Clinical Practice Guideline for Management of Osteoporosis and Fracture Prevention in Canada: 2023 Update. Consult the full guideline document at https://osteoporosis.ca/2023-clinical-practice-guideline/*
- *Healthcare Providers: Osteoporosis Canada*. Osteoporosis Canada (2024, https://osteoporosis.ca/healthcare-providers/)

PATIENT INFORMATION		**REFERRING PHYSICIAN INFORMATION**	
Name:		Name:	
Gender:		Telephone:	
Date of Birth:		Fax:	
Address:		Family Physician (if *not* referral source):	
Health Card Number:		**Brief Patient History:**	
Telephone:			
Email:			
Consent for Email? ☐ Yes ☐ N			
Prior Consultation? ☐ Yes ☐ N			
Caregiver Required? ☐ Y ☐ N			
Translator Required? ☐ Y ☐ N			
Mechanical Lift Required? ☐ Y ☐ N			
Language:			

Reason for Referral (Please check all that apply):

☐ **Hip Fracture Pathway** (*LHSC and SJHC ONLY*)
Started on treatment? ☐ Yes ☐ No
If Yes: ☐ Zoledronic Acid ☐ Denosumab ☐ Evenity
Treatment start date (*yyyy/mm/dd*): _____

Bolded items are high priority

☐ **Vertebral compression fracture (fragility)**
☐ **Hip fracture (fragility)**
☐ Diagnosis of osteoporosis (T-score ≤ -2.5)
☐ Other fragility fracture (e.g., wrist, humerus)
☐ High fracture risk (per FRAX or CAROC assessment)
☐ Paget's Disease
☐ Calcium Disorders
☐ Adverse effects or intolerance to anti-osteoporosis medications:
_____
☐ Failure of anti-osteoporosis medications:
_____
☐ Other (please specify): _____

☐ **Rare bone diseases:**
☐ Fibrodysplasia ossificans progressiva (FOP)
☐ X-linked hypophosphatemia (XLH)
☐ Hypophosphatasia (HPP)
☐ Osteogenesis imperfecta (OI)
☐ Other (please specify):
_____

Clinical Information

1. Relevant Medical History
    a. Prior fractures (site, type, and date): _____/_____/_____
    b. Vertebral compression fracture: ☐ Yes ☐ N
    c. Hip fracture: ☐ Yes ☐ N
    d. Other (site/date): _____/_____
    e. Naive to osteoporosis treatment: ☐ Yes ☐ N
    f. Current anti-osteoporosis medication:
        i. Duration: _____ Past: _____ Last dose: _____
    g. Falls in the past year: ☐ Yes ☐ N
    h. Secondary causes of osteoporosis (e.g. early menopause, please list):
    _____

2. Investigations
    a. Most recent BMD (DXA) results (attach report if available):
        i. Date: _____ Location of test (hospital site): _____
        ii. Site(s)/T-score(s) Lumbar spine: _____ Femoral neck: _____ Total hip: _____
        iii. FRAX/CAROC risk category (if known): _____

Required Investigations
Must be completed prior to booking; the referral will be returned if not provided

X-rays:
☐ Lateral thoracic and lumbar vertebral X-ray (*N/A for recent hip fracture*)

Blood Work:
☐ Corrected serum calcium (adjusted for albumin)
☐ Parathyroid hormone (PTH)
☐ 25-hydroxyvitamin D
☐ Alkaline phosphatase (ALP)
☐ Phosphate
☐ Creatinine
☐ Magnesium

Signature of Referring Provider:		Date:	

Thank you for your referral. We will review and respond within 14 days as per CPSO Guidelines.