

Osteoporosis and Bone Disease Program
 268 Grosvenor St.
 London, ON N6A 4V2
 Phone: 519-646-6000 ext. 64434
 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? <input type="checkbox"/> Yes <input type="checkbox"/> N			
Prior Consultation? <input type="checkbox"/> Yes <input type="checkbox"/> N			
Caregiver Required? <input type="checkbox"/> Y <input type="checkbox"/> N			
Translator Required? <input type="checkbox"/> Y <input type="checkbox"/> N			
Mechanical Lift Required? <input type="checkbox"/> Y <input type="checkbox"/> N			
Language:			
Reason for Referral (Please check all that apply):			
<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <input type="checkbox"/> Hip Fracture Pathway (LHSC and SJHC ONLY) Started on treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: <input type="checkbox"/> Zoledronic Acid <input type="checkbox"/> Denosumab <input type="checkbox"/> Evenity Treatment start date (yyyy/mm/dd): _____ </div> <p><i>Bolded items are high priority</i></p> <input type="checkbox"/> Vertebral compression fracture (fragility) <input type="checkbox"/> Hip fracture (fragility) <input type="checkbox"/> Diagnosis of osteoporosis (T-score ≤ -2.5) <input type="checkbox"/> Other fragility fracture (e.g., wrist, humerus) <input type="checkbox"/> High fracture risk (per FRAX or CAROC assessment) <input type="checkbox"/> Paget's Disease <input type="checkbox"/> Calcium Disorders <input type="checkbox"/> Adverse effects or intolerance to anti-osteoporosis medications: _____ <input type="checkbox"/> Failure of anti-osteoporosis medications: _____ <input type="checkbox"/> Other (please specify): _____		<input type="checkbox"/> Rare bone diseases: <input type="checkbox"/> Fibrodysplasia ossificans progressiva (FOP) <input type="checkbox"/> X-linked hypophosphatemia (XLH) <input type="checkbox"/> Hypophosphatasia (HPP) <input type="checkbox"/> Osteogenesis imperfecta (OI) <input type="checkbox"/> 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.