Osteoporosis and Bone Disease Program
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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.