

OSTEOPOROSIS REQUESTS

OSTEOPOROSIS UNIT LEVEL 2 BLUE ZONE MEDWAY MARITIME HOSPITAL WINDMILL ROAD GILLINGHAM KENT ME7 5NY
TEL: 01634 833892 EMAIL: met-tr.osteo@nhs.net FAX: 01634 846661

TO BE COMPLETED IN FULL BY REFERRING CLINICIAN ONLY

Form v3.0 Aug 2012

Affix Patient Label Here If Available <i>The following information must be provided:</i> Patient Name Katrina Margery Patient DoB 24-May-1967 Patient Address Wing Road Leysdown-On-Sea Sheerness Kent ME12 4QR Hospital Number NHS Number 400 067 0514 Telephone Number MOB: 07484257634	Examination Required: DEXA scan
	In – Patient / NO Ward:
	If weight over 120KG contact osteoporosis Mobility Difficulties YES/NO If Yes please comment:
	Is an ambulance required NO Interpreter required? NO Language:
Clinical Details and Relevant History: <i>(e.g. Surgery, Allergies, Medication, previous scans)</i> Hx of osteoporosis for which on alendronic acid. Last dexa scan was in July 2022.Repeat recommended in 3 years and now due.	Referrer (MUST be signed by referring clinician) Name: Dr Ogunnowo Job Title: GP GP/Consultant: Dr Ogunnowo
	Contact / Bleep No:
	Practice / Hospital: St Georges Medical Centre St Georges Avenue, Sheerness, Kent, ME12 1OU Date: 30 July 2025
	Signature: T Ogunnowo

TO BE COMPLETED BY NUCLEAR MEDICINE STAFF ONLY

Authorisation <i>(to be completed by ARSAC Holder or Delegated Authoriser under NM Department procedures)</i> ARSAC Holder (initials): Date: Authorised By (sign): Views Required / Comments:	Pregnancy <i>(to be completed on day of admin)</i> Patient's Signature Confirming Negative Pregnancy / Breastfeeding Status (12-55yrs) Date: Practitioner's Justification if Pregnant and Proceeding with Exposure:
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FORM RECEIVED ON: (DD/MM/YY)

BOOKING DETAILS AND CONFIRMATION

CONTACT DATE	DATE	TIME	CLINIC CODE AND DATE	LETTER SENT	REASON FOR CANCELLATION/CHANGE