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| Direct Access DEXA Scan Request Form |  |

**Patient Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Hospital no. | ${Hospital ID|integer} | NHS no. | ${NHS number|integer} | | |
| Surname | ${Last name} | Forenames | ${First name} | | |
| Previous surname | ${Previous last name} | Title | ${Title) | Sex | ${Sex} |
| Date of birth | ${Date of birth|date} |  | | | |
| Address | ${Address} | Home tel. no. | ${Home telephone number|Integer} | | |
|  | Work tel. no. | ${Work telephone number|Integer} | | |
|  | Mobile no. | ${Mobile telephone number|Integer} | | |
| Postcode |

**Referral Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Referring clinician | ${Your name} | Date of referral | ${now} |  |  |
| GP practice / department | ${GP practice} | New referral? | ${New referral|radio|Yes} | Re-ferral? | ${New referral|radio|No} |

**Communication needs:**

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