NOTE: Incomplete and / or unsigned requisition will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

OSTEOPOROSIS CLINIC REFERRAL FORM

Markham Site Booking Line: 905-472-7601
Please Fax To: 905-472-7621

Hospital MRN #: _____

Patient Name: _____
Last First

Date of Birth: _____ Sex: F M
Day Month Year

Health Card # _____ Version Code: _____

Telephone # (Best Daytime): _____

Alternate #: _____

Email: _____

Date	**Referring MD**	**Signature**

Address	**Fax**	**Telephone**

Family MD (if different from Referring MD)

Address	Fax	Telephone

Spoken Language if other than English	Contact Information for Translator if Required (Name & Number)

Reason for Referral

- ☐ History of Current Fragility Fracture
- ☐ History of Osteoporosis on Treatment
- ☐ History of Osteoporosis Not on Treatment

Diagnostics Required (please attach to this referral)

- ● Most recent Bone Mineral Density results
  Previous BMD Date: _____
- ● Recent blood work relevant to OP assessment

For fracture clinic only:

- ☐ Bone Mineral Density
  Previous BMD Date: _____

Comments

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