***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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____