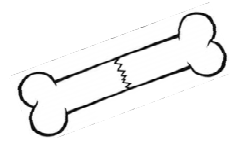


**Osteoporosis Referral Form**

Phone 250 940 4444 Fax 250 385 9600



<b>Date:</b>	
<b>PATIENT INFORMATION:</b> (affix label or complete) Name: PHN: DOB: Address: Cell Phone: Home Phone: Email: Secondary Contact:	<b>REFERRING PHYSICIAN:</b> (affix label or complete) Name: MSP: Address: Phone: Fax:  <b>FAMILY PHYSICIAN:</b>
<b>Urgency of Referral:</b>	<input type="checkbox"/> Urgent (Please call to discuss case) 250-940-4444, ext 5012 <input type="checkbox"/> Semi-Urgent <input type="checkbox"/> Non-Urgent
<b>Type of fracture:</b> <input type="checkbox"/> N/A <input type="checkbox"/> Vertebral <input type="checkbox"/> Hip <input type="checkbox"/> Wrist <input type="checkbox"/> Other	<b>Date of fracture:</b> _____
<b>Bone Density:</b> <input type="checkbox"/> N/A <input type="checkbox"/> Attached <input type="checkbox"/> Pending	<b>Year performed:</b> _____
<b>Previous treatments for osteoporosis (and duration of therapy):</b>	
<b>Past Medical History:</b>	<b>Current Medications:</b>
<b>Reason for referral:</b>	
Letter Attached <input type="checkbox"/>	

Patients will be contacted directly by Rebalance<sup>MD</sup> to schedule appointment.

Referring physicians will be advised by fax once this referral has been received, and, again, when an appointment has been offered to the patient

*Dr. Xin Feng, MD FRCPC  
Endocrinologist*