Alphington Sports Medicine

339 Heidelberg Road, Northcote VIC 3070
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OSTEOPENIA/OSTEOPOROSIS & FALLS PREVENTION CLASS REFERRAL FORM

Patient Details:

Title ..... First Name ..... Surname .....

Date Of Birth ...../...../.....

Name of Doctor .....

Practice Name .....

Practice Email .....

Medical History:

Have you been diagnosed with any of the following conditions:

☐ Osteoporosis or Osteopenia	☐ Malabsorptive Disease (e.g. coeliac, Crohn's)	☐ Arthritis (e.g. Rheumatoid Arthritis, Osteoarthritis)
☐ Overactive Thyroid or Parathyroid	☐ Early menopause/low testosterone	☐ Chronic Kidney Disease or Liver Disease
☐ Type 1 or Type 2 Diabetes	☐ Epilepsy	☐ Cancer (e.g. Breast or Prostate)
☐ Pelvic Floor Condition	☐ Heart Condition (e.g. CVD, Heart Failure, Angina, Arrhythmias)	☐ Lung Condition (e.g. Asthma, COPD)
☐ Fracture	☐ Hernia	☐ Neurological Condition (e.g. Parkinson's Disease, Multiple Sclerosis)
☐ Cognitive Impairment	☐ Hyper/Hypotension	☐ High Cholesterol
☐ Other, please specify:		

Please provide additional details on any of the above conditions you have ticked:
(e.g. Osteoporosis/Osteopenia T-score & location, fracture location, how well controlled is condition)

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Have you suffered any falls in the last 12 months? ☐ Yes ☐ No
If yes, how many times, and how did it/they occur:

Have you spent time in hospital (including day admission) for any condition/illness/injury during the last 12 months? ☐ Yes ☐ No
If yes, please provide details:

Any additional medical history:

Medications:

Are you taking any medications? ☐ Yes ☐ No
If yes, please list below:
(e.g. glucocorticoids, anti-epilepsy treatment, thyroxine, aromatase inhibitors, immunotherapies)