Southern Ultrasound

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DEXA SCAN – REFERRAL FORM

Patient Details

Full Name: _____ Gender: ☐ Male ☐ Female

NHI Number: _____ Date of Birth: ___ / ___ / _____

Phone: _____ Email: _____

Residential Address: _____

Funding Details

☐ Self-Funded

☐ Insurance
Insurance Company: _____ Membership Number: _____

Examination Requested

☐ Bone Mineral Density (BMD)
☐ Body & Bone Composition
☐ Total Body Composition
☐ Repeat Total Body Composition

Relevant or Previous Imaging (if any): _____

Clinical Information / Reason for Referral

_____

_____

_____

Referrer Details

☐ **Self-Referred**

Name: _____ **Date:** ___ / ___ / _____

Signature: _____

Copies of results to: _____