



# Mature Women's Centre

3 North - 2340 Pembina Highway, Winnipeg, MB R3T 2E8  
Tel: (204) 477-3505 Fax: (204) 275-0919  
www.maturewomenscentre.ca

## OSTEOPOROSIS CLINIC REFERRAL FORM

### Patient Demographic Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ MHSC #: \_\_\_\_\_  
PHIN #: \_\_\_\_\_ Other Provincial Healthcare # or Military #: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

### Reason For Referral

Low Trauma Fracture: Wrist  Hip  Vertebral  Other   
Low BMD  Osteoporosis Risk Factors  Osteopenia on X-Ray

Please elaborate on the above/other reason for referral: \_\_\_\_\_

Has patient previously been seen at the Mature Women's Centre? Yes  No

**NOTE: Please provide us with copies of previous BMD reports, X-ray reports, recent lab reports, and any other pertinent information.**

### Osteoporosis Medications

(bisphosphonates, hormone therapy, raloxifene, nasal calcitonin, denosumab, teriparatide, other)

#### Please List

#### Length of Time on Medication

|       |                                   |                                   |                                   |                               |                                  |
|-------|-----------------------------------|-----------------------------------|-----------------------------------|-------------------------------|----------------------------------|
| _____ | <input type="checkbox"/> < 1 Year | <input type="checkbox"/> > 5 Year | <input type="checkbox"/> >10 Year | <input type="checkbox"/> Past | <input type="checkbox"/> Present |
| _____ | <input type="checkbox"/> < 1 Year | <input type="checkbox"/> > 5 Year | <input type="checkbox"/> >10 Year | <input type="checkbox"/> Past | <input type="checkbox"/> Present |
| _____ | <input type="checkbox"/> < 1 Year | <input type="checkbox"/> > 5 Year | <input type="checkbox"/> >10 Year | <input type="checkbox"/> Past | <input type="checkbox"/> Present |

**Steroids** \_\_\_\_\_  < 3 Month  > 6 Month  Past  Present

**Other current medications** (please list): \_\_\_\_\_

**Lifestyle** Caffeine Intake: \_\_\_\_\_ cups/day ETOH: \_\_\_\_\_ drinks/week Smoker: Yes  No

### Physician Information

Referring Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Family Physician (if different from above): \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

### Physician Signature

\_\_\_\_\_

For additional copies of this form, as well as more information regarding the Mature Women's Centre programs and current/updated information and links please go to [www.maturewomenscentre.ca](http://www.maturewomenscentre.ca)