Health
Northern Sydney
Local Health District

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. DD / MM / YYYY	M.O.
ADDRESS	
	PH
M/C	FIN
LOCATION / WARD	ADM DD / MM / YYYY
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

REF08862

GP REFERRAL FORM

Osteoporosis Refracture Prevention Clinic
Clinic 1
Ambulatory Care Centre, Level 3, ASB
Royal North Shore Hospital
Reserve Road, St Leonards NSW. 2065
Ph: 9462 9745 / 9463 1848

TO: Prof Lyn March, A/Prof Rory Clifton Bligh and associates

Re: **DOB:** **MRN:**

I am referring the above named patient to the **Osteoporosis Refracture Prevention Service** at Royal North Shore Hospital, for assessment and management of fracture risk.

This patient meets the inclusion criteria:

- ☐ Aged ≥ 50 years (or post-menopausal if younger)
- ☐ At least one minimal trauma fracture
- ☐ No known metastatic or myeloma bone disease / pathological fracture
- ☐ Patient consents to referral

Fracture site: _____ **Date of fracture:** _____

Return completed referral to NSLHD-RNS-ORP@health.nsw.gov.au

Signed: _____ **Date:**__ __ / __ __ /__ __

Name: _____

Provider Number: _____

Please send all correspondence regarding this patient to:

Surgery Stamp:

REFERRING LETTERS