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

Osteoporosis Refracture Prevention Clinic
Graythwaite Rehabilitation Centre
Ryde Hospital
Level 1, 37 Fourth Avenue
Eastwood NSW 2122
Ph: 98587155 Fax: 98587091

GP REFERRAL FORM

To: Osteoporosis Re-fracture Prevention Service (Dr Mojgan Mansouri)

RE:_____ DOB: MRN_____

I am referring the above named patient to the **Osteoporosis Refracture Prevention Service** at Graythwaite Rehabilitation Centre (Ryde Hospital) for assessment and management of fracture risk.

This patient meets the inclusion criteria: (please check the boxes below)

- ☐ 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

Clinical Information: Fracture site…….. Fracture date …….

Please indicate if the patient has had a Bone Density in the past 2 years Yes ☐ No ☐

EMAIL COMPLETED REFERRAL TO NSLHD-GraythwaiteRehabilitation@health.nsw.gov.au

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

Name: _____

Provider Number: _____

Please send all correspondence regarding this patient to:

Surgery Stamp:

REFERRING LETTERS