

## Glasgow Physiotherapy Service for Osteoporosis

<b>Date of referral:</b>	<b>*Diagnosis (code):</b>				
<b>Source of referral:</b>					
<input type="checkbox"/> <b>DADS</b>	<i>GRI</i>	<i>WGI</i>	<i>SGH</i>	Stobhill	<i>(Please circle)</i>
<input type="checkbox"/> <b>Fracture Liaison Service</b>	<i>GRI</i>	<i>WGI</i>	<i>SGH</i>	Stobhill	<i>(Please circle)</i>
<input type="checkbox"/> <b>Bone Metabolism Clinic</b>	<i>GRI</i>	<i>WGI</i>	<i>SGH</i>	Stobhill	<i>(Please circle)</i>
<input type="checkbox"/> <b>GP</b>	<input type="checkbox"/> <b>Self-referral</b>	<input type="checkbox"/> <b>PT</b>	<input type="checkbox"/> <b>Other (Please state)</b>		

<b>Name:</b>	<b>CHI No: (or date of birth if not known)</b>	<b>Age:</b>
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<b>Address:</b>	<b>GP's name and address:</b>	
<b>Postcode:</b>	<b>Post code:</b>	
<b>Tel:</b>		

<b>Osteoporosis &amp; Falls History:</b> Reason for DXA:	<b>Fracture History: (incl. site and year)</b>	
<b>Diagnosis:</b> osteoporosis / osteopenia <i>(delete as approp)</i> Date of diagnosis:		
<b>Previous falls?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>How many? _____</i> Cause of falls?		
Dizziness/loc? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of last fall?		

<b>Medical history: (incl details if box ticked)</b>								
	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>	High BP	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	H/o cancer	<input type="checkbox"/>	<input type="checkbox"/>	Joint problems	<input type="checkbox"/>	<input type="checkbox"/>

*Clarification and any other health problems:*

General health & mobility:

Hearing impairment:  No  Yes      Visual impairment:  No  Yes

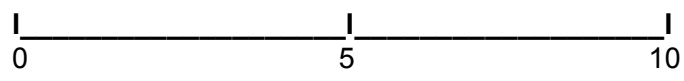
Smoker:  No  Yes \_\_\_\_\_ /day      If ex-smoker, how long stopped?

<p><b>Social History:</b> <i>(incl. work/hobbies, home situation, care packages etc)</i></p>	<p><b>Current medication:</b></p> <p><i>For osteoporosis:</i></p> <p><i>General:</i></p>
<p><b>Exercise &amp; physical activity history:</b></p> <p>&lt; 4 hours on feet daily? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Current activity/exercise:</p> <p>Previous activity/exercise:</p>	
<p><b>Patient's perception of exercise</b> <i>eg. attitudes/beliefs, interests, barriers etc</i></p>	

**PAIN:**

**Assessment 1**

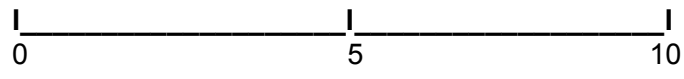
Areas of pain:



Site:

**Assessment 2**

Areas of pain:



Site:

