DEXA UNIT

Clinical Age Assessment Unit

Tel: 061-482623

Mid Western Regional Hospital
Limerick

Fax: 061-482509

Patient Details:

Surname .....

First Name .....

Address .....

.....

.....

Tel. No. .....

DOB ..... M / F *(please circle)*

Hospital No. .....

Inpatient / Outpatient *(please circle)*

Ward *(if relevant)* .....

Private: Y / N *(please circle)*

Has patient had a previous DEXA at this unit? Y / N

(please circle)

If Yes, how many? .....

Date .....

Referring Doctor Details:

Name .....

Address .....

.....

.....

.....

Signature .....

Clinical Details:

Office Use Only: *(Please Tick)*

Accept ☐

Inadequate Clin Info ☐

Inappropriate ☐

Repeat Scan not due/indicated ☐

Signature .....