

# OSTEOPOROSIS COMMUNICATION FORM

Pharmacy Name: \_\_\_\_\_

Name of patient: \_\_\_\_\_

NHS patient number: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Dear Doctor \_\_\_\_\_

Date: \_\_\_\_\_

**Patient currently taking:**

- |                  |                          |           |                 |                          |                  |                          |
|------------------|--------------------------|-----------|-----------------|--------------------------|------------------|--------------------------|
| Didronel PMO     | <input type="checkbox"/> | Switch to | Alendronic acid | <input type="checkbox"/> | + Calcium/Vit D3 | <input type="checkbox"/> |
| Alendronic acid  | <input type="checkbox"/> | Requires  | Calcium/Vit D3  | <input type="checkbox"/> |                  | <input type="checkbox"/> |
| Calcium          | <input type="checkbox"/> | Switch to | Alendronic acid | <input type="checkbox"/> | + Calcium/Vit D3 | <input type="checkbox"/> |
| Seretide 500     | <input type="checkbox"/> | requires  | Alendronic acid | <input type="checkbox"/> | + Calcium/Vit D3 | <input type="checkbox"/> |
| Prednisolone 5mg | <input type="checkbox"/> | requires  | Alendronic acid | <input type="checkbox"/> | + Calcium/Vit D3 | <input type="checkbox"/> |

**FOR DOCTORS USE ONLY:-**

Issue prescription and inform pharmacy

Do not issue prescription  
Reason for not issuing prescription:

.....  
.....  
.....

I need to see the patient