**MACRO – Osteoporosis LOW RISK**

DISCHARGE NOTE: LOW RISK

**Letter to Primary Care Provider**

XXX is being discharged from the endocrine/osteoporosis clinic.

Rationale for discharge from Endocrine Care:

Your patient is low risk for osteoporosis fracture and meets the following criteria:

* Stable clinical risk factors for bone loss (not anticipated to change in next 2-5 years)
* No fragility fracture within 5 years
* No prior fragility fracture of hip or spine

Their fracture risk was calculated using the FRAX tool with the following specifications:

1. 10-year major osteoporotic fracture risk: \_\_\_\_\_\_
2. Country database: \_\_\_\_\_
3. Positive risk factors for: \_\_\_\_\_

Surveillance:

1. Bone density can be repeated in 5-10 years to reassess fracture risk. This should take place at xxx imaging facility to allow for serial comparison, if possible.
2. Fracture risk should be reassessed earlier with clinical assessment and repeat bone density if the following occurs:
	1. Change in clinical status resulting in new risk factors for bone loss (ie start of glucocorticoid therapy, new condition affecting GI absorption, etc)
	2. New fragility fracture (which is a fracture after a fall from standing height or less, excludes hands, feet, skull, face)
3. Consider an x-ray lumbar/thoracic spine to assess for vertebral fractures if the following occurs:
	1. New findings of kyphosis
	2. New findings of height loss > 4 cm
	3. Back pain with vertebral tenderness

Criteria for considering pharmacotherapy or re-referral:

* New calculated FRAX fracture risk is moderate-high risk (>/= 15%) or T-score at any site is < = -2.5
* New fragility fracture (excludes hands, feet, skull, face)

**MACRO – Osteoporosis HIGH RISK**

DISCHARGE NOTE: HIGH RISK REQUIRING LIFE-LONG THERAPY

**Letter to Primary Care Provider**

XXX is being discharged from the endocrine/osteoporosis clinic.

Rationale for discharge from Endocrine Care:

Your patient has been found to be high risk for osteoporosis fractures and will require lifelong therapy [with denosumab (Prolia) or bisphosphonate]. They meet the following criteria for discharge:

* Currently on osteoporosis therapy with denosumab, and tolerating it well and demonstrating good compliance after xxx years.
* High risk due to hip fracture or other recent major fragility fracture(s)
* High risk based on FRAX calculation with continued clinical factors for accelerated bone loss
* Stable BMD after xxx years of osteoporosis therapy
* No new fractures on current osteoporosis therapy

Their fracture risk was calculated using the FRAX tool with the following specifications:

1. 10-year major osteoporotic fracture risk: \_\_\_\_\_\_
2. Country database: \_\_\_\_
3. Positive risk factors for: \_\_\_\_

Surveillance:

1. [ ] Your patient will require ongoing therapy for their osteoporosis with Denosumab every 6 months. I have provided a prescription for 1 year and have asked the patient to request future refills from you [add details of LU code].
2. [ ] Your patient will require ongoing therapy for their osteoporosis with a bisphosphonate. I have provided a prescription for 1 year and have asked the patient to request future refills from you [add details of LU code].
3. Bone density can be repeated in 3 years to reassess fracture risk. This should take place at xxx imaging facility to allow for serial comparison if possible.
4. Reassess your patient in 1 year clinically to ensure adherence with therapy, and then every 2-3 years as needed.
5. Fracture risk should be reassessed earlier with clinical assessment and repeat bone density if the following occurs:
	1. Change in clinical status resulting in new risk factors for bone loss (ie start of glucocorticoid therapy, new condition affecting GI absorption, etc)
	2. New fragility fracture (which is a fracture after a fall from standing height or less, excludes hands, feet, skull, face)
6. Can consider a spinal x-ray to assess for vertebral fractures if the following occurs:
	1. New findings of kyphosis
	2. New findings of height loss > 4 cm
	3. Back pain with vertebral tenderness
7. If new thigh, groin, or buttock pain develops, please assess for atypical femoral fracture (AFF) beginning with an x-ray of the femur (bilateral)
8. The patient has been advised to inform their dentist that they are taking long-term antiresorptive therapy, given the risk of osteonecrosis of the jaw (especially with more invasive dental procedures)

Criteria for escalation or re-referral:

* Can re-refer for expediated osteoporosis assessment if:
	+ Patient not tolerating osteoporosis medication and still considered high risk, to discuss alternative therapy
	+ New fragility fracture, despite good adherence with osteoporosis therapy
	+ Decline in BMD by greater than 5% at the spine or hip, or based on least significant change for the DEXA machine used
	+ Development of serious adverse side effects of anti-resorptive therapy, such as atypical femoral fracture or osteonecrosis of the jaw

**MACRO – Osteoporosis DRUG HOLIDAY**

DISCHARGE NOTE: DRUG HOLIDAY

**XXX is being discharged from the endocrine/osteoporosis clinic.**

Rationale for discharge from Endocrine Care:

Your patient has been found to be clinically stable while on a drug holiday from their osteoporosis medication and meet the following criteria:

* Completed xxx years of therapy with xxxx medication with adequate response
* No new fracture for the past 2-5 years
* Stable clinical risk factors for bone loss (not anticipated to change in next 2-5 years)

Their fracture risk was calculated using the FRAX tool with the following specifications:

1. 10-year major osteoporotic fracture risk: \_\_\_\_\_\_\_\_
2. Country database: \_\_\_\_
3. Positive risk factors for: \_\_\_\_

Surveillance:

1. Bone density should be repeated in 3 years to reassess fracture risk. This should take place at xxx imaging facility to allow for serial comparison if possible.
2. Fracture risk should be reassessed earlier with clinical assessment and repeat bone density if the following occurs:
	1. Change in clinical status resulting in new risk factors for bone loss (ie start of glucocorticoid therapy, new condition affecting GI absorption, etc)
	2. New fragility fracture occurs (excludes hands, feet, skull, face)
3. Can consider a spinal x-ray to assess for vertebral fractures if the following occurs:
	1. New findings of kyphosis
	2. New findings of height loss > 4 cm
	3. Back pain with vertebral tenderness

Criteria for restart of previous bisphosphonate +/- re-referral

* Change in clinical status (i.e. significant decline in BMD, new secondary risk factor for fractures)
	1. New fragility fracture while on drug holiday (which is a fracture after a fall from standing height or less, excludes hands, feet, skull, face)

Criteria for re-referral:

* Patient may benefit from anabolic therapy
	+ Multiple new fractures (especially spine), ONJ, AFF
* Patient not able to tolerate osteoporosis therapy that has been restarted after a drug-holiday

**MACRO – Osteoporosis – DECLINE THEREAPY**

DISCHARGE NOTE: DECLINE THERAPY

**Letter to Primary Care Provider**

XXX is being discharged from the endocrine/osteoporosis clinic.

Rationale for discharge from Endocrine Care:

Your patient has been found to be moderate/high risk for osteoporosis fractures and pharmacotherapy was recommended to reduce their fracture risk.

At this time, your patient has expressed a desire to not initiate or continue osteoporosis pharmacotherapy, \_\_\_\_\_\_\_\_\_.

Their fracture risk was calculated using the FRAX tool with the following specifications:

* 1. 10-year major osteoporotic fracture risk: \_\_\_\_\_\_\_\_
	2. Country database: \_\_\_\_\_
	3. Positive risk factors for: \_\_\_\_\_

Next Steps:

1. Bone density can be repeated in 3 years to reassess fracture risk. This should take place at xxx imaging facility to allow for serial comparison if possible.
2. Fracture risk should be reassessed earlier with clinical assessment and repeat bone density if the following occurs:
	1. Change in clinical status resulting in new risk factors for bone loss (ie start of glucocorticoid therapy, new condition affecting GI absorption, etc)
	2. New fragility fracture (which is a fracture after a fall from standing height or less, excludes hands, feet, skull, face)
3. Can consider a spinal x-ray to assess for vertebral fractures if the following occurs:
	1. New findings of kyphosis
	2. New findings of height loss > 4 cm
	3. Back pain with vertebral tenderness
4. If the patient is agreeable to start pharmacotherapy, they can be initiated on therapy with \_\_\_\_\_\_, and their BMD can be repeated in 3 years.