BONE DENSITOMETRY REQUISITION

PATIENT INFORMATION

(Affix Patient Label/Identification Here)

MRN:____________________ HCN:___________________________
Name:____________________
Sex:____________ Date of Birth:_______/_____/______
Address:____________________ Telephone:____________ Alternate #:____________

REFERRING HEALTH CARE PROVIDER TO COMPLETE:

1. Has this patient ever had a Bone Mineral Density (BMD) test in Ontario?
   □ No ► This patient has never had a BMD test in Ontario
   □ Yes ► When?___________________________ Where? □ WCH □ Other► specify:___________________________

2. If this is a repeat BMD test: Is this patient considered to be high risk and therefore eligible for a BMD prior to 3 or 5 years after baseline or the last test?
   a) □ Yes ► At risk for accelerated bone loss* with Low Bone Density or Osteoporosis
      OR
   b) □ Yes ► At risk for accelerated bone loss* with bone loss in excess of 1% per year on last BMD
   c) □ No ► OHIP will cover a second BMD after 3 years from a baseline test or successive BMD tests (3rd or more) after 5 years from the last test.

3. Has this patient sustained a low trauma fracture after age 40?
   □ No □ Yes ► □ Wrist □ Hip □ Spine □ Rib □ Other bones ► specify:___________________________

4. Is this patient currently taking oral steroids? □ No □ Yes

5. Clinical & Other Relevant History (required if answered “No” to #2c, #3 and #4 above):

   ______________________________________________________________________________________
   ______________________________________________________________________________________

6. Has this patient had spinal and/or hip surgery? □ No □ Yes ► specify:___________________________

7. Is this patient still menstruating? □ Yes* □ No ► At what age did periods stop?___________________________

   * WARNING: This test should not be performed if the patient is or might be pregnant

REFERRING PROVIDER INFORMATION

Name:____________________
Address:____________________
Telephone:____________________
Fax:____________________
Billing #: ______________________________ Signature:____________________

PATIENT INSTRUCTIONS:

1. Bring Ontario health card to all appointments
2. MUST NOT TAKE ANY CALCIUM TABLETS ON THE DAY OF THEIR TEST.
3. Preferably wear comfortable clothing with no zippers or large buttons/objects

SPECIAL NEEDS: Please inform us at the time of booking so we may accommodate the patient better