Bone Mineral Densitometry

HALIBURTON HIGHLANDS HEALTH SERVICES

Fax: 705 – 457 – 1071

Booking Line: 705 – 457 – 1392 Ext. 2381

DATE TO BE DONE BY/WITHIN

_____

- ☐ 2 Days
- ☐ 7 Days
- ☐ 10 Days

- ☐ Outpatient
- ☐ Inpatient

Room: _____

Date of Requisition: _____

Name: _____

Health Card #: _____

Birthdate: _____

Phone: _____

Ordering Physician: _____

Family Physician: _____

CC Physician: _____

WSIB ☐ No ☐ Yes

Injury Date: _____

Claim #: _____

Exam Type:

- ☐ Baseline (once per lifetime and patient over 65 years of age; or for younger patients, risk factors must be checked below)
- ☐ High Risk Follow-Up (1 year + a day since previous; must check at least one risk factor below)
- ☐ Low Risk 2nd BMD (must be 36 months + a day since previous)
- ☐ Low Risk Follow-Up (3rd BMD and subsequent; must be 60 months + a day since previous)

Risk Factors: (please check all that apply):

- ☐ T-score less than -1.0 on prior BMD
- ☐ Fragility fracture (spine, wrist, hip, pelvis)
- ☐ Systemic Glucorticoid (Steroid) Use (for greater than 3 months)
- ☐ Other risk medications (please specify): _____
- ☐ Malabsorption syndrome
- ☐ Chronic Inflammatory Disease
- ☐ Vertebral Fracture
- ☐ Low Body Mass (less than 60kg)
- ☐ Significant weight loss
- ☐ Smoker
- ☐ Other (please specify): _____

Relevant Clinical Information: _____

Physician Signature: _____