London Health Sciences Centre

BMD REQUISITION

Scheduling and Bookings Information:

Phone: 519-685-8770 **Fax:** 519-667-6826

Date (YYYY/MM/DD): _____

PLEASE PRINT WHEN COMPLETING FORM

PATIENT INFORMATION: (Plate)

NAME: _____
Last First

PIN #: _____ ☐ MALE ☐ FEMALE

DOB (YYYY/MM/DD): _____

HC#: _____ VERS. CODE: _____

ADDRESS: _____

PHONE: _____

Physician Information or Other Authorized Health Care Provider:

Name (Last, First):	
Phone:	Fax:
Provider Billing #:	Provider Signature:
Copy to:	

Patient Information Continued:

Most recent BMD scan (YYYY/MM/DD):	Location of last scan:
Next BMD scan due (YYYY/MM/DD):	

Does this patient have any special needs or impairments? (Please specify):

_____

Exam Type:

- ☐ Baseline (once per lifetime and patient over 65 years of age; or for younger patients, risk factor(s) 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 – 36 months since previous
- ☐ Low Risk Follow-Up 3rd BMD and Subsequent – 60 months since previous

Clinical Indication (reason for exam)
(Check ALL THAT APPLY ☑)

- ☐ Anorexia Nervosa
- ☐ Asymptomatic Primary Hyperparathyroidism
- ☐ Corticosteroid Therapy
- ☐ Chronic Renal Failure
- ☐ Crohn's disease or ulcerative colitis
- ☐ Cushing's Syndrome
- ☐ Estrogen Deficiency (female)
- ☐ Height loss of more than 2 inches
- ☐ Hyperthyroidism, Hyperparathyroidism
- ☐ Insulin-dependent diabetes
- ☐ Longstanding poor mobility (e.g., following a stroke, Parkinson's disease, or spinal injury)
- ☐ Malabsorption
- ☐ Osteomalacia
- ☐ Osteoporosis
- ☐ Ovarian or Testicular Hypofunction
- ☐ Pre-transplant Evaluation
- ☐ Prostate Cancer (male)
- ☐ Radiographic Osteopenia
- ☐ Renal Osteodystrophy
- ☐ Rheumatoid Arthritis
- ☐ Testicular Dysfunction (male)
- ☐ Use of Depo Provera
- ☐ Use of post breast cancer drug therapy
- ☐ Vertebral Abnormality

Other: _____

Medical Information Questionnaire:
(Must be completed in full)

Yes	No	
☐	☐	Do you have a family history of osteoporosis?
☐	☐	Are you post-menopausal?
		If yes, at what age was your last menstrual period? (Age) _____
☐	☐	Have you had your uterus removed (Hysterectomy)?
		If yes, at what age was it removed? (Age) _____
☐	☐	Have you had either ovary removed (Oophorectomy)?
		If yes, at what age was it removed? (Age) _____
☐	☐	Do you presently take estrogen or progesterone medications?
☐	☐	Do you take thyroid medication regularly?
☐	☐	Do you take prednisone or another steroid medication regularly?
☐	☐	Did you ever fracture (break) your hip?
☐	☐	Did you ever fracture (break) your spine?
☐	☐	Did you ever fracture (break) your wrist?
☐	☐	Have you had other fractures (breaks) since age 40?
☐	☐	Have you had surgery on either of your hips?
☐	☐	Have you had surgery on your spine?

Contraindications:

- Suspected pregnancy
- Within 5 days of scheduled appointment, administration of radiopaque contrast (such as barium for Upper GI study, Barium Enema, CT with barium)
- Within 3 days of scheduled appointment, administration of nuclear medicine radioactive isotope?

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