Soldiers' MEMORIAL HOSPITAL Orillia

ISO 15189 Plus™ Accredited IQMH Diagnostic Imaging

Tel: **705-327-9115** Fax: **705-325-3985**

REQUEST FOR

# Bone Density Exam

**• BY APPOINTMENT ONLY •**

**PATIENT INFORMATION** | MRN N°. | Isolation Status

☐ **IN-PATIENT** ☐ **OUT-PATIENT** ☐ **ER** ☐ **AHF**

| Last Name | First Name | ☐ M ☐ F |
|---|---|---|

| Date of Birth (D/M/Y) | Health Card N°. | WSIB N°. | 3rd Party Ins. N°. |
|---|---|---|---|

| Address | City | Postal Code |
|---|---|---|

| Email Address | Contact Number | ☐ OK to leave voice mail message |
|---|---|---|

**Patient is able to give consent for this procedure:** ☐ **Yes** ☐ **No**

**Does the patient have a glucose monitoring device?** ☐ **Yes** ☐ **No**

**If patient unable to give consent, please ensure SDM attends with the patient and has appropriate documentation.**

☐ **SDM Name:** ☐ **SDM Contact Information:**

☐ **Patient requires assistance to complete this imaging exam,** *e.g. mobility, translation* **Please Specify:**

**Weight (max 350lb):** _____

**Please specify the patient's fracture risk using prior BMD, FRAX or an equivalent tool (required):**

☐ **Low risk (< 10%)** ☐ **Medium risk (10%-15%)** ☐ **High Risk (> 15%)**

**SPECIFIC EXAM REQUIRED (check all that apply):**

- ☐ Baseline Study (once per lifetime, never had BMD in Ontario)
- ☐ Subsequent Test (once every 60 months) *
  - ☐ Low or Medium Risk Patient
- ☐ Subsequent Test (once every 36 months) *
  - ☐ High Risk Patient
  - ☐ Therapy Monitoring
  - ☐ Risk factor for secondary osteoporosis consistent with Canadian clinical practice guidelines
  - ☐ New fragility fracture. Date of fragility fracture: _____
  - ☐ Other risk factor for rapid bone loss *
- ☐ Additional test /other risk factors (once every 12 months)
  - ☐ Hypercortisolism / Cushing's Syndrome
  - ☐ High-dose glucocorticoid therapy of >20mg Prednisone equivalent per day
  - ☐ Other risk factors *

**CLINICAL QUESTION AND RELEVANT CLINICAL INFORMATION**
(Must be provided and must be specific)

**REQUIRED FOR ALL SUBSEQUENT TESTS**

PREVIOUS EXAM DATE: _____ PREVIOUS LOCATION: _____

| **Physician's Name** (Please PRINT clearly) | **Phone #** | **CPSO #** |
|---|---|---|
| **Address #** | **Billing #** | **Fax #** |

Physician's Signature

**INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.**