

Bone Mineral Density Referral Form

Please complete all sections and fax to 519-357-3688

1. Patient Information: Please use patient label or complete: Last Name: _____ Health Card No: _____ VC: _____ First Name: _____ Address: _____ Date of Birth: ____/____/____ City: _____ Postal Code: _____ Day Month Year Contact #: _____ Interpreter required <input type="checkbox"/> No <input type="checkbox"/> Yes, Language _____ Mobility: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Mechanical lift	
2. Referring Physician Information: Ref. Physician Name: _____ Tel.: _____ Address: _____ Fax NO: _____ City: _____ Billing No: _____ Family Physician: _____	
3. Prior BMD: *Please attach reports done outside of Wingham* Prior BMD: <input type="checkbox"/> None <input type="checkbox"/> Wingham site <input type="checkbox"/> other Facility & Date: _____	
4. Rx Information: Osteoporosis Therapy Rx: _____ Initiation Date: _____ Patient on steroid treatment-Rx: _____ Dose and Duration: _____	
5. Exam ordered: <input type="checkbox"/> BMD- Baseline exam (first BMD in Ontario) <input type="checkbox"/> BMD- Low risk for osteoporosis (1 st low risk follow up BMD must >3 years after baseline or >5years after last low risk exam) <input type="checkbox"/> BMD – High risk for osteoporosis (high risk follow up BMD must be >1 year after baseline or > 1 year after last high risk exam) <input type="checkbox"/> Other: _____	
6. Reason for Referral * Required History/Fragility Fractures: _____ _____ _____ <i>If patient has had previous fragility fractures, please list age at time of fracture</i>	Wingham DI use only: Protocol: _____ Exam Date: _____
Physician Signature: _____	DATE: _____ Day Month Year

Preparation: Please refer patients at least 5 days after any nuclear medicine or xray contrast exam. Please no calcium supplements day of and do not wear any metal in clothing, if possible.