DIAGNOSTIC IMAGING – BONE MINERAL DENSITY

BMD

	MD Name:	Patient Name:
	Signature:	DOB:
	MD Phone:	HCN:
	Date: (d/m/y)	Home Phone:
FAX ALL REQUISITIONS TO:	Copies to:	Cell Phone
613-969-5561	WSIB #:	Address:

A BOOKING WILL NOT BE MADE UNLESS THIS REQUISITION IS COMPLETED IN FULL

CLINICAL INDICATION:

CONTRAINDICATIONS:

NO CONTRAST MEDIA 5 DAYS PRIOR
NO NUCLEAR MEDICINE PROCEDURES 7 DAYS PRIOR
NO CALCIUM TABLETS 24 HOURS PRIOR
WEIGHT LIMIT FOR SPINE/HIP MEASUREMENT + 350 LBS

BONE MINERAL DENSITY

BGH

TMH

Follow-up exams should ideally be performed at the same site.

BASELINE

ROUTINE FOLLOW UP

HIGH RISK

Fragility Fractures

Parental Hip Fracture

Smoker

Systemic Glucocorticoid

Rheumatoid Arthritis

DEPARTMENT USE ONLY:

DATE OF LAST BMD:

LOCATION OF LAST BMD: **BGH** **TMH** **OUTSIDE FACILITY**

BASELINE **1ST FOLLOW-UP** **LOW RISK/FURTHER FOLLOW-UP** **HIGH RISK FOLLOW-UP**

Appointment Date & Time:_______________________________

PLEASE ENSURE REQUISITION IS COMPLETE. FAX REQUISITION TO 613 969 5561

Rev:2019