Thunder Bay Regional Health Sciences Centre

Diagnostic Imaging

BONE MINERAL DENSITY
CONSULTATION REQUEST

Regional Inpatient? **Yes ☐** **No ☐**
Is the patient hearing impaired? **Yes ☐** **No ☐**

Appointment Date and Time: _____

Guidelines:
1. Physician to complete requisition. Incomplete requisitions will be returned resulting in delay of study.
2. Fax requisitions including Regional referral to Diagnostic Imaging Central Intake **855-978-1862**.

Patient Name: _____ ☐ In-Patient ☐ Out-Patient

Address: _____ Date of Birth _____ /_____ /_____
day month year

_____ Postal Code: _____

Home Phone Number: _____ Work Phone Number: _____ Sex: ☐ Male ☐ Female

Health Insurance Card Number: _____ Version Code: _____

Workplace Safety and Insurance Board (WSIB) Claim Number: _____

Area to be measured:

☐ Spine ☐ Hip ☐ Wrist ☐ Whole Body

Patient's Height _____ Patient's Weight _____

Clinical Information: _____

_____

_____

Osteoporosis Questionnaire:

1. Has the patient ever had:
   a) previous bone mineral density done here ☐ Yes ☐ No
   b) previous bone mineral density done at another facility ☐ Yes ☐ No
      if yes, where and when _____
   c) back surgery ☐ Yes ☐ No
   d) hip surgery ☐ Yes ☐ No
2. Is the patient presently being treated for osteoporosis? ☐ Yes ☐ No
3. Is there any chance of pregnancy? ☐ Yes ☐ No

Physician's Name (please print): _____

Physician's Signature: _____ **Date**: _____

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Cross-reference: Osteoporosis Questionnaire FCS-205