Diagnostic Imaging

BONE MINERAL DENSITY
CONSULTATION REQUEST

Patient Name:______________________________
D.O.B. (YYYY-MM-DD):______________________
Address:__________________________________
City/Town, Prov:___________________________
Postal Code: ____________Tel: ______________
Health Card #: ______________Version: ____
Place Patient Label with Barcode HerePlace

Regional Inpatient? **Yes** ☐ **No** ☐
Is the patient hearing impaired? **Yes** ☐ **No** ☐
Does patient require an interpreter? **Yes** ☐ **No** ☐

Appointment Date and Time: ________________________

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

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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

Healthcare Provider's Name (please print): ________________________________

Healthcare Provider's Signature: ______________________________ **Date**: _____________

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Cross-reference: Osteoporosis Questionnaire FCS-205