

## Bone Mineral Density Requisition

**Office Use Only:**

Date Rec'd: \_\_\_\_\_

Appt Date & Time: \_\_\_\_\_

Patient Information			
Patient Name:		DOB (dd/mm/yyyy)	
Address:		City	Province    Postal Code
Phone number:	Alternate number:	OHIP:	

**Previous BMD test?**    ☐ No    This request is a baseline test

☐ Yes    **When?** \_\_\_\_\_

**Where?**    ☐ Mount Sinai    ☐ Princess Margaret    ☐ Toronto General    ☐ Toronto Western

☐ TRI Lyndhurst    ☐ Other \_\_\_\_\_

**Is patient considered High Risk by OHIP guidelines?**

☐ Yes. Patient with an expected bone loss in excess of 1% per year

☐ No. Low risk. OHIP will cover 2<sup>nd</sup> BMD after 3 years from baseline and successive BMD (3<sup>rd</sup> scan or more) is covered 5 years from the last scan.

☐ Not OHIP covered. Patient will pay for the scan.

**Does the patient require a lift?**

☐ No    ☐ Yes

**Does the patient have hyperparathyroidism or need 2<sup>nd</sup> site to scan (can't scan either hip or spine)?**

☐ No    ☐ Yes, add forearm BMD scan

**Has patient had a previous fracture as an adult?**

☐ No    ☐ Yes, specify \_\_\_\_\_

**Did the patient's parent fractured their hip?**

☐ No    ☐ Yes, ☐ Mother    ☐ Father

**Is patient taking oral glucocorticoids?**

☐ No    ☐ Yes

**Does patient have Rheumatoid arthritis?**

☐ No    ☐ Yes

**Relevant Medical History, risk factors:** \_\_\_\_\_

**Referring Physician Information:**

**Name:** \_\_\_\_\_ **OHIP Billing no.:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Tel:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please fax referral to the CESHA Program:**

**UHN:** 416-340-4707

**MSH:** 416-586-8790

**TRI:** 416-597-7042

**For questions, please call**

**UHN:** 416-340-3890

**MSH:** 416-586-4446

**TRI:** 416-597-3422 ext. 6591