CESHA
Centre of Excellence in Skeletal Health Assessment

Bone Mineral Density Requisition

Office Use Only:
Date Rec'd: ______________________

Appt Date & Time: ______________________

Patient Information				
Patient Name:			**DOB (dd/mmm/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 ____

Please select one of the following:

- ☐ High risk patient according to FRAX or osteo pharmacotherapy initiation or management (once every 3 years)
- ☐ Moderate or Low risk patient (once every 5 years)
- ☐ Additional test to inform therapeutic patient management based on generally accepted standards of care (once every 12 months). Referring physicians must document the clinical circumstance requiring more frequent testing.
- ☐ Not OHIP covered. Patient will pay for the scan.

Does the patient require a lift? ☐ No ☐ Yes

Does the patient have hyperparathyroidism or need 2nd 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