DIAGNOSTIC IMAGING – BONE MINERAL DENSITY

BMD

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