Haldimand War Memorial Hospital

BONE MINERAL DENSITY REQUISITION

PATIENT DEMOGRAPHICS		
Name:	DOB:	Sex: ☐ Male ☐ Female ☐Other
Health Card #:	Phone #:	City:
Street Name:	Postal Code:	

PREVIOUS BMD	
Last Scan Date:	Facility of Prior BMD:

EXAM TYPE – SELECT ONE

☐**Baseline**
Once per lifetime – all ages

☐**Subsequent – Low Risk Routine**
Age ≥ 50 *(60 Months)*
☐Low Risk ≤ 10%
☐Moderate Risk 10% to 20%

☐**Subsequent – High Risk Routine**
Age ≥ 50 *(36 Months)*
☐High Risk ≥ 20%
☐On Osteoporosis Pharmacotherapy-Monitoring

☐**Diagnostic / Medically Necessary**
Any age | *May be performed within 12 to 36 months*
☐New Fragility Fracture
Aprx Date of Fracture: _____
☐Secondary Osteoporosis – Specify cause in next section
☐Medication-Induced Bone Loss (e.g. cancer therapies) Specify: _____
☐Therapy Transition /Initiation of Pharmacotherapy
☐Patient ≤ 50 yrs – No Interval Restriction
☐Other Scenario Requiring Reassessment ≤ 36 Months

☐**Additional – Annual**
Min. Interval:12 Months
☐Hypercortisolism/ Cushing's Syndrome
☐Glucocorticoid ≥ 20mg Prednisone Equiv./day

SECDONDARY OSTEOPOROSIS RISK FACTOR(S)

Drugs/Medication
☐Glucocorticoid Steroids (<20mg prednisone equiv./day)
☐Anticonvulsants (Phenytoin, Phenobarbital
☐GnRH Agonists/Antagonists
☐Cancer Chemotherapy
☐Immunosuppressants (e.g. Cyclosporine)
☐ Other _____

Endocrine Disorders
☐Hyperparathyroidism
☐ Hyperthyroidism
☐Diabetes Mellitus (Type 1 or Type 2)
☐ Primary Ovarian Failure/Early Menopause
☐ Other _____

Gastrointestinal & Nutritional
☐Inflammatory Bowel Disease
☐Celiac Disease
☐Bariatric Surgery
☐Other Malabsorptive Syndrome
☐Chronic Liver Disease
☐ Malnutrition/Parenteral Nutrition
☐Vitamin D and/or Calcium Deficiency
☐ Other _____

Rheumatologic
☐Rheumatoid Arthritis
☐Other Inflammatory Arthritis
☐Systemic Lupus Erythematosus

Genetic
☐ Osteogenesis Imperfecta
☐Hypophosphatasia
☐ Other Genetic Cause of Osteomalacia

Other Disorders
☐Multiple Myeloma
☐Other Marrow-related Disorders
☐Chronic Kidney Disease / Renal Failure
☐Chronic Obstructive Pulmonary Disease
☐Organ Transplantation
☐ Parkinson's Disease
☐Other Neuromuscular Disorder
☐Prolonged Immobilization
☐ Paget's Disease
☐ Acquired Osteomalacia
☐ Other _____

CLINICAL INDICATION

Clinical Indication (state specifically):

Date Request: _____

Referring Physician Rationale (why testing now/earlier than usual interval):

Referring physician:	**OHIP Billing #:**	**Fax Number:**

Physician Signature: *****Please Provide Patient's Medication List*****