



Diagnostic Imaging

BONE MINERAL DENSITY CONSULTATION REQUEST

Is the patient hearing impaired? ☐ Yes ☐ No

Appointment Date and Time: _____

Guidelines:

1. Physician to complete requisition. Incomplete requisitions will be returned resulting in delay of study.
2. **Requisition is to be faxed to the Regional Booking Office at 807-684-5907.**
3. Completed requisitions will be filed in the Booking Office.

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: _____

Osteoporosis Questionnaire:

1. Has the patient ever had:

a) previous bone mineral density done here	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) previous bone mineral density done at another facility	<input type="checkbox"/> Yes	<input type="checkbox"/> No
if yes, where and when _____		
c) back surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) hip surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is the patient presently being treated for osteoporosis? ☐ Yes ☐ No
3. Is there any chance of pregnancy? ☐ Yes ☐ No

Physician's Name (please print): _____

Physician's Signature: _____ Date: _____