Bone Densitometer Unit
Gynaecology Out-Patients
Mater Dei Hospital
email: bonedensity.mdh@gov.mt

REQUEST FOR BONE DENSITY MEASUREMENT

Name:_____ **Surname**:_____

Address:_____

ID Card No:_____ **Age:**_____ **Primary/Secondary Care:** ☐

Clinical indication:_____ **Country of Origin** _____

Gender ☐ **Weight** **kg** **Height** **cm**

BMI ☐

History of Previous Fracture[1]	☐	Site_____ Year_____
Family history of hip fracture	☐	(If ***Yes***, ☐)
Tobacco smoking	☐	(If ***Yes***, number daily _____)
Alcohol 3 or more units daily	☐	
History of glucocorticoid use[2]	☐	
Secondary Osteoporosis	☐	
Confirmed Rheumatoid arthritis	☐	

FRAX Score **10 year probability of major osteoporotic fracture** ☐

10 year probability of hip fracture ☐

Current Treatment:

_____

Calcium &Vit D: _____ **Other:** _____

Antiresorptive treatment: _____

Doctor Requesting Test ☐ **Medical Register No** ☐

Signature: ☐ **Date** ☐

Contact Telephone Details: H_____ **M**_____

All fields must be completed.
No appointment will be given unless request form is filled in completely and legibly

New case / Follow-up _____ **Norland** ☐ **Hologic** ☐ **Other** ☐

Last done in:_____ **To be repeated in:** ☐

1. A previous fracture denotes more accurately a previous fracture in adult life occurring spontaneously, or a fracture arising from trauma which, in a healthy individual, would not have resulted in a fracture.
2. Enter yes if the patient is exposed to oral glucocorticoids or has been exposed to oral glucocorticoids for more than 3 months at a dose of prednisolone of 5mg daily or more (or equivalent doses of other glucocorticoids)