

XRAY/BONE MINERAL DENSITOMETRY REQUISITION

Depending on wait times, patients may be scheduled at any of our hospital sites in the Niagara region

<input type="checkbox"/> INPATIENT	<input type="checkbox"/> OUTPATIENT
<input type="checkbox"/> ED REQUEST	<input type="checkbox"/> NEXT AVAILABLE
<input type="checkbox"/> UNIT _____	<input type="checkbox"/> WITHIN 1-2 WEEKS
<input type="checkbox"/> URGENT	<input type="checkbox"/> ROUTINE

APPOINTMENT DATE/TIME/SITE: _____
DD / MM / YYYY HH : MM SITE

PATIENT INFORMATION (PLEASE PRINT) ORDERING PROVIDER INFORMATION

PATIENTS LAST NAME		PATIENTS FIRST NAME		ORDERING PROVIDER NAME	COPIES TO
ADDRESS		CITY		PHONE NUMBER	URGENT RESULTS CONTACT #
MOBILE PHONE (PREFERRED CONTACT METHOD)	HOME PHONE	PROVINCE	POSTAL CODE	SIGNATURE	FAX NUMBER
OHCN/OHIP#	VERSION CODE	PATIENT WEIGHT	DATE OF BIRTH (DD/MM/YYYY)	GENDER	<input type="checkbox"/> WSIB CLAIM #:
CAN THE PATIENT COME IN ON SHORT NOTICE? <input type="checkbox"/> YES <input type="checkbox"/> NO			DOES THE PATIENT HAVE ANY ACCESSIBILITY ISSUES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, SPECIFY:		
CAN WE CONTACT YOU BY EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE PROVIDE YOUR EMAIL ADDRESS:					

IT IS THE REFERRING PROVIDERS RESPONSIBILITY TO NOTIFY THE PATIENT OF APPOINTMENT DETAILS

CLINICAL INFORMATION/REASON FOR EXAM (INCLUDE SPECIFIC QUESTIONS TO BE ANSWERED)

X-RAY

PHONE: 905-378-4647 <input type="checkbox"/> ST CATHARINES X46350 FAX: 905-323-7560 <input type="checkbox"/> NIAGARA FALLS/FORT ERIE SITE X54812 FAX: 905-358-7438 <input type="checkbox"/> WELLAND/PORT COLBORNE SITE X33280 FAX: 905-732-9537	GENERAL X-RAY PROCEDURES EXAMINATION REQUESTED: <input type="checkbox"/> 3 FT LEG LENGTHS* <input type="checkbox"/> SCOLIOSIS* <input type="checkbox"/> PRE-OP KNEE / HIP WITH MARKER
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SPECIAL RADIOLOGY PROCEDURES <input type="checkbox"/> BARIUM SWALLOW <input type="checkbox"/> UPPER GI SERIES <input type="checkbox"/> SMALL BOWEL ONLY <input type="checkbox"/> BA ENEMA (PREP NEEDED) <input type="checkbox"/> CYSTOGRAM	PROVIDE DETAILS: _____ _____ _____
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BONE DENSITY

PHONE: 905-378-4647 <input type="checkbox"/> ST CATHARINES X46350 FAX: 905-323-7560 <input type="checkbox"/> NIAGARA FALLS X54952 FAX: 905-358-4956 <input type="checkbox"/> WELLAND X33285 FAX: 905-397-1917	FACTORS FOR FRACTURE AND RISK ASSESSMENT (PHYSICIAN MUST FILL IN ALL RELEVANT PATIENT INFORMATION BELOW)	
	MAJOR RISK FACTORS <input type="checkbox"/> VERTEBRAL COMPRESSION FRACTURE <input type="checkbox"/> FRAGILITY FRACTURE AFTER AGE 40 <input type="checkbox"/> FAMILY HISTORY OF OSTEOPOROTIC FRACTURE <input type="checkbox"/> SYSTEMIC GLUCOCORTICOID THERAPY 3 MONTHS <input type="checkbox"/> MALABSORPTION SYNDROME <input type="checkbox"/> PRIMARY HYPERPARATHYROIDISM <input type="checkbox"/> PROPENSITY TO FALL <input type="checkbox"/> OSTEOPENIA APPARENT ON X-RAY FILM <input type="checkbox"/> HYPOGONADISM <input type="checkbox"/> EARLY MENOPAUSE (BEFORE AGE 45)	MINOR RISK FACTORS <input type="checkbox"/> RHEUMATOID ARTHRITIS <input type="checkbox"/> PAST HISTORY OF HYPERTHYROIDISM <input type="checkbox"/> CHRONIC ANTICONVULSANT THERAPY <input type="checkbox"/> LOW DIETARY CALCIUM INTAKE <input type="checkbox"/> SMOKER <input type="checkbox"/> EXCESSIVE ALCOHOL INTAKE <input type="checkbox"/> EXCESSIVE CAFFEINE INTAKE <input type="checkbox"/> WEIGHT < 57 KG <input type="checkbox"/> WEIGHT LOSS > 10% OF WEIGHT AT AGE 25 <input type="checkbox"/> CHRONIC HEPARIN THERAPY

BONE MINERAL TESTING RECOMMENDATIONS: 1 MAJOR RISK FACTOR OR 2 MINOR RISK FACTORS

RISK FACTOR OTHER THAN LISTED ABOVE: _____

PREVIOUS BONE DENSITY DATE: _____

BASELINE LOW RISK HIGH RISK (1 MAJOR OR 2 MINOR RISK FACTORS OR PREVIOUS BMD EVIDENCE OF OSTEOPOROSIS, OSTEOPENIA OR > 1% BONE LOSS/YEAR)

PATIENT INSTRUCTIONS

- DO NOT TAKE CALCIUM WITHIN 24 HOURS OF THE TEST
- PATIENT MUST REGISTER AT PATIENT REGISTRATION

~HOSPITAL USE ONLY~

PLEASE NOTE: INCOMPLETE REQUISITIONS WILL BE RETURNED/FAXED BACK WITHOUT AN APPOINTMENT