niagarahealth
Extraordinary Caring. Every Person. Every Time.

XRAY/BONE MINERAL DENSITOMETRY REQUISITION

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

☐ INPATIENT ☐ OUTPATIENT
☐ ED REQUEST ☐ NEXT AVAILABLE
☐ UNIT_____ ☐ WITHIN 1-2 WEEKS
☐ URGENT ☐ ROUTINE

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

PATIENT INFORMATION (PLEASE PRINT)

PATIENTS LAST NAME	PATIENTS FIRST NAME		
ADDRESS	CITY		
MOBILE PHONE (PREFERRED CONTACT METHOD) / HOME PHONE	PROVINCE / POSTAL CODE		
OHCN/OHIP# / VERSION CODE / PATIENT WEIGHT	DATE OF BIRTH (DD/MM/YYYY) / GENDER		

ORDERING PROVIDER INFORMATION

ORDERING PROVIDER NAME	COPIES TO
PHONE NUMBER	URGENT RESULTS CONTACT #
SIGNATURE	FAX NUMBER
☐ WSIB CLAIM #:	

CAN THE PATIENT COME IN ON SHORT NOTICE? ☐ YES ☐ NO
DOES THE PATIENT HAVE ANY ACCESSIBILITY ISSUES? ☐ YES ☐ NO IF YES, SPECIFY:
CAN WE CONTACT YOU BY EMAIL? ☐ YES ☐ 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

☐ **ST CATHARINES** X46350 FAX: 905-684-6990

☐ **NIAGARA FALLS/FORT ERIE SITE** X54812 FAX: 905-358-7438

☐ **WELLAND/PORT COLBORNE SITE** X33280 FAX: 905-732-9537

GENERAL X-RAY PROCEDURES

EXAMINATION REQUESTED:

☐ 3 FT LEG LENGTHS* ☐ SCOLIOSIS* ☐ PRE-OP KNEE / HIP WITH MARKER

SPECIAL RADIOLOGY PROCEDURES

☐ BARIUM SWALLOW
☐ UPPER GI SERIES
☐ SMALL BOWEL ONLY
☐ BA ENEMA (PREP NEEDED)
☐ *ASPIRATION (JOINT)
☐ **JOINT INJECTIONS (SPECIFY JOINT)
☐ CYSTOGRAM

PROVIDE DETAILS:

***SPECIFIC LAB ORDERS REQUIRED, ****PLEASE NOTE IF PREVIOUSLY ATTEMPTED UNSUCCESSFULLY**

BONE DENSITY

PHONE: 905-378-4647

☐ **ST CATHARINES** X46350 FAX: 905-684-6990

☐ **NIAGARA FALLS** X54952 FAX: 905-358-4956

☐ **WELLAND** X33285 FAX: 905-397-1917

FACTORS FOR FRACTURE AND RISK ASSESSMENT (PHYSICIAN MUST FILL IN ALL RELEVANT PATIENT INFORMATION BELOW)

MAJOR RISK FACTORS	MINOR RISK FACTORS
☐ VERTEBRAL COMPRESSION FRACTURE	☐ RHEUMATOID ARTHRITIS
☐ FRAGILITY FRACTURE AFTER AGE 40	☐ PAST HISTORY OF HYPERTHYROIDISM
☐ FAMILY HISTORY OF OSTEOPOROTIC FRACTURE	☐ CHRONIC ANTICONVULSANT THERAPY
☐ SYSTEMIC GLUCOCORTICOID THERAPY 3 MONTHS	☐ LOW DIETARY CALCIUM INTAKE
☐ MALABSORPTION SYNDROME	☐ SMOKER
☐ PRIMARY HYPERPARATHYROIDISM	☐ EXCESSIVE ALCOHOL INTAKE
☐ PROPENSITY TO FALL	☐ EXCESSIVE CAFFEINE INTAKE
☐ OSTEOPENIA APPARENT ON X-RAY FILM	☐ WEIGHT < 57 KG
☐ HYPOGONADISM	☐ WEIGHT LOSS > 10% OF WEIGHT AT AGE 25
☐ EARLY MENOPAUSE (BEFORE AGE 45)	☐ 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

1. DO NOT TAKE CALCIUM WITHIN 24 HOURS OF THE TEST
2. PATIENT MUST REGISTER AT PATIENT REGISTRATION

~HOSPITAL USE ONLY~

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

Version 3: OCT2025