HALIBURTON HIGHLANDS HEALTH SERVICES

Bone Mineral Densitometry

Booking: 705-457-1392 Ext. 2381 * Fax: 705-457-1071

Patient Name: _____ Ordering Physician: _____

Date of Birth: _____ Family Physician: _____

Health Card #: _____ CC Physician: _____

Sex at birth: ☐ Male ☐ Female ☐ Other

Phone: _____

Exam Type:

- ☐ Baseline (once per lifetime)
- ☐ Subsequent Test - Low or medium-risk follow-up (once every 60 months)
- ☐ Subsequent Test - High-risk follow-up (once every 36 months)
- ☐ Other risk factors/ Very high-risk follow-up (once every 12 months)

Prior BMD Date: _____ Location: _____

☐ Report Attached (if not completed at HHHS)

Risk Factors: (please check all that apply):

- ☐ Fragility fracture (spine, wrist, hip, pelvis)
- ☐ Systemic glucocorticoid (Steroid) use (>3 months)
  Dose: _____ Name: _____
- ☐ Other risk medications (please specify): _____
- ☐ Malabsorption syndrome
- ☐ Chronic inflammatory disease
- ☐ Low Body Mass (<60 kgs)
- ☐ Significant weight loss
- ☐ Smoker
- ☐ Other (please specify): _____

Relevant Clinical Information:

_____

_____

Physician Signature: _____

Date: _____