St.Thomas Elgin General Hospital

BMD Requisition

Last Name:_____
First Name:_____**Middle Initial**_____
Preferred Name:_____
Gender:_____**DOB(YMD):**_____
Address:_____
City:_____**Postal Code:**_____
Home Pnone:_____
Alternate Phone:_____
Health Card _____

REFERRED BY
Name: _____
OHIP Billing # _____
Telephone#:_____
Fax #:_____
CC Physician:_____
Date:_____
Signature:_____

Please check which scan is most accurate. If the patient has never had a BMD scan before, proceed to **section A**. If they have had a BMD scan in their lifetime, proceed to **section B.** If ordering a follow-up, please check the patient's previous BMD report for their FRAX score before ordering. If the BMD was performed elsewhere, please provide a copy of the previous report.

A. Baseline Scan **[Once per the patient's lifetime]**

- ☐ Baseline
  Please provide history_____

B. Follow Up Scan

i. Low risk/medium risk **[5 years (60 months) + 1 day from previous]**

- ☐ Low risk - FRAX <10%
- ☐ Medium risk - FRAX 10%-15%

ii. High risk **[3 years (36 months) + 1 day from previous]**

- ☐ High risk - FRAX >15%
- ☐ Therapy monitoring
  - 36 months after initiating pharmacotherapy
  - 36 months after stopping bisphosphonate therapy

iii. Additional test **[1 year + 1 day from previous]**

- ☐ Hypercortisolism/Cushing's syndrome
- ☐ Patient receiving high-dose glucocorticoid therapy of > 20 mg Prednisone equivalent per day
- ☐ Provider clinical decision. (For cases in which BMD testing is required more frequently for extraordinary diagnostic purposes or therapeutic patient management.) **Please state reason:**
  _____
  _____