



# Bone Mineral Density (BMD) Referral Form

Please complete all sections and fax to (519) 646-6135

## 1. Patient information

Last name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Gender: M F Date of birth (YYYY/MM/DD): \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

## 2. INSURANCE / BILLING / RESEARCH

Health card number: \_\_\_\_\_ Version Code: \_\_\_\_\_  
 WCB Employer: \_\_\_\_\_ S.I.N.# \_\_\_\_\_ ACCIDENT DATE: \_\_\_\_\_  
 (YYYY/MM/DD)  
 Research study?  No  Yes  
 If yes, (required): Lawson approval/CRIC# \_\_\_\_\_ Study name: \_\_\_\_\_

## 3. PATIENT SUPPORT NEEDS:

Preferred language  English  Other: \_\_\_\_\_ Interpreter required?  No  Yes  
 Mobility  Ambulatory  Wheelchair  Stretcher  Portable  Mechanical lift required  
 Diabetes  No  Yes Pregnant  No  Unknown  Yes, \_\_\_\_\_ weeks

## 4. Allergies: None If patient has known latex or contrast allergy, please notify as soon as possible at (519) 646-4137

## 5. Exam requested: Bone Mineral Density (BMD)

Routine BMD, Spine/Hip  VFA  Whole Body

Diagnosis suspected: \_\_\_\_\_

Clinical Findings and History:

## 6. Referring Health Care Provider

Last name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ OHIP Billing Number: \_\_\_\_\_  
 Copy to: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_

Radiology department use only: Appointment date: