St. Joseph's Hospital
Medical Imaging Program
268 Grosvenor St., PO Box 5777, Stn. B
London, ON N6A 4V2
Tel. 519-646-6000 ext. 64137

Bone Mineral Density (BMD) Referral Form

Please complete all sections and send to St. Joseph's Hospital by **fax to (519) 646-6135**

1. PATIENT INFORMATION

Last name: _____ First Name: _____ Middle initial: ____

Date of birth (YYYY/MM/DD): _____ Age: _____ Preferred name: _____

Birth sex: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to disclose Pronouns: _____

Address: _____ City: _____ Postal Code: _____

Phone #: _____ Health card number: _____ Version Code: _____

Diabetes? ☐ No ☐ Yes **Pregnant?** ☐ No ☐ Yes **Interpreter required:** ☐ No ☐ Yes, language: _____

Mobility ☐ Wheelchair ☐ Stretcher ☐ Mechanical lift required

Research study? ☐ No ☐ Yes, Lawson approval # **R-**_____ Study name: _____

2. EXAM REQUEST:

Risk factors for osteoporosis: Clinical practice guideline for management of osteoporosis and fracture prevention in Canada: 2023 update | CMAJ (www.cmaj.ca/content/195/39/E1333)

a. Date of last BMD Exam (YYYY-MM-DD): _____ ☐ None

b. Referral for BMD – please check category:

☐ **BASELINE** (once per lifetime and patient age 50+ years) Once per lifetime

☐ **LOW RISK Follow-up** FRAX <10%, no other risk factors (5 years +1 day from previous)

☐ **MEDIUM RISK Follow up** FRAX 10%-15%, no other risk factors (5 years +1 day from previous)

☐ **HIGH RISK Follow-up, specify** FRAX 15% or therapy monitoring (3 years +1 day from previous)

- ☐ FRAX >15%
- ☐ Therapy Monitoring (36 months after pharmacotherapy start or 36 months after bisphosphonate therapy end)
- ☐ Provider clinical decision - Reason: _____

☐ **HIGH RISK – OTHER follow-up, specify** (1 year +1 day from previous)

- ☐ Hypercortisolism / Cushing's Syndrome
- ☐ Patient on high-dose glucocorticoid therapy
- ☐ Provider clinical decision - Reason: _____

c. Please select: ☐ Routine BMD, Spine/Hip ☐ VFA ☐ Forearm ☐ Whole Body

d. Relevant clinical info: _____

3. Referring Health Care Provider Info

Last name: _____ First Name: _____

Address: _____ City: _____

Phone: _____ Fax: _____ OHIP Billing Number: _____

Copy to: _____ Copy fax: _____

Signature: _____ Date: _____

Department use only: Appointment date: