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 fax to St. Joseph's Hospital at (519) 646-6135

1. PATIENT INFORMATION

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

Birth sex: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to disclose **Date of birth** _____ (YYYY/MM/DD)

Preferred name: _____ Pronouns: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Alternate Phone: _____

Health card number: _____ Version Code: _____

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

2. PATIENT SUPPORT NEEDS:

Preferred language ☐ English ☐Other: _____ Interpreter required? ☐ No ☐ Yes

Mobility ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Portable ☐ Mechanical lift required

Diabetes: ☐ No ☐ Yes **Pregnant:** ☐ No ☐ Yes

3. EXAM REQUESTED:

☐ **Bone Mineral Density (BMD), please select:**

☐ Routine BMD, Spine/Hip ☐ VFA ☐ Forearm ☐ Whole Body

Exam type:

- ☐ **Baseline** (once per lifetime and patient over 65 years of age; or, for younger patients who are high risk)
- ☐ **High Risk Follow-up** (1 year + a day since previous)
- ☐ **Low Risk Second (2nd) BMD** (36 months since previous)
- ☐ **Low Risk Follow-up** (Third (3rd) and subsequent – 60 months since previous)

Relevant clinical information: _____

_____

4. Referring Health Care Provider

Last name: _____ First Name: _____

Address: _____ City: _____

Phone: _____ Fax: _____ OHIP Billing Number: _____

Copy to: _____ Copy fax: _____

Signature: _____ Date: _____

Radiology department use only: Appointment date: