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 (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: