Brockville General Hospital

BONE DENSITY PLEASE FAX COMPLETED REQUISITION/QUESTIONNAIRE TO 613-345-8324

Phone # 613-345-5649 Ext. 51128

Last Name:_____ First Name: _____ Date of Birth:_____

Address:_____ City:_____ Postal Code:_____

Phone Number:_____ Health Card #:_____VC:____

ON THE DAY OF YOUR TEST DO **NOT** TAKE YOUR CALCIUM PILL & TRY TO WEAR CLOTHING WITH **NO METAL**

CLINICAL INFORMATION

Patients's height? _____ feet _____ inches Weight? _____pounds

Have you had a previous bone mineral density exam here or elsewhere in Ontario?	Yes ☐ No ☐
If yes when? _____	
Have you had any surgery on your back or your hips?	Yes ☐ No ☐
Have you had a nuclear medicine test or x-ray with contrast material (i.e. barium) in the last 2 weeks?	Yes ☐ No ☐
Do you smoke, or have you ever smoked? If yes, for how long? _____ years	Yes ☐ No ☐
Do you take calcium supplements (including Tums)?	Yes ☐ No ☐
If yes, how many milligrams? _____ mgs and for how long _____?	
Are you taking or have you ever taken (please circle any that apply)	Yes ☐ No ☐
FOSAMAX – how long? _____ DIDROCAL – how long? _____	
EVISTA – how long? _____ ACTONEL? – how long? _____	
PROLIA – how long? _____ ACLASTA? – how long? _____	
Have you been on Prednisone or steroids for more than 3 months in 1 year?	Yes ☐ No ☐
If yes, is the amount you took 7.5 mg or more in 1 day?	
Do you take medication for your thyroid?	Yes ☐ No ☐
If yes, for how long? _____	
Are you taking medications for rheumatoid arthritis?	Yes ☐ No ☐
Has anyone in your family had osteoporosis?	Yes ☐ No ☐
Have you had any broken bones as an adult?	Yes ☐ No ☐
Have you ever had cancer?	Yes ☐ No ☐

Have you had a hysterectomy or your ovaries removed? When? _____	Yes ☐ No ☐
If yes, please circle what applies:	
Uterus ONLY Ovaries ONLY Uterus AND Ovaries	
Are you post-menopausal (periods have stopped)? If yes, when? _____	Yes ☐ No ☐
Are you taking or have you ever taken hormone replacement therapy (HRT)?	Yes ☐ No ☐
If yes, what is or was the dose? _____ How long? _____	
Are you pregnant?	Yes ☐ No ☐

Ordering Provider Name:_____(Please print)

Ordering Provider Signature:_____(Please sign) **Date:**_____

Physician CC:_____ **Fax #**_____

Booking Office Use

Date:_____**Time:**_____**Confirmed:** _____