PLEASE BRING THIS PAPER WITH YOU TO YOUR APPOINTMENT

BRANT COMMUNITY HEALTHCARE SYSTEM

200 Terrace Hill Street

Brantford, Ontario N3R 1G9

(519) 751-5599 FAX (519) 751-5582

BONE MINERAL DENSITY REQUISITION (BMD)

Name:_____

Address:_____

City/Province:_____Postal Code:_____

Phone: Home:_____ Other: _____

Health Card # _____

DOB DD/MM/YYYY _ _ / _ _ / _ _ _ _

Appointment Date and Time	BCHS Unit #

Please check		Patient to be accompanied/needs assistance		Baseline
				Low Risk
		Patient Ambulatory		High Risk(1 major or 2 minor risk factors or previous BMD evidence of osteoporosis, osteopenia or >1% bone loss/year)
History and Clinical Information				

Please check		Major Risk Factors		Minor Risk Factors
		Age greater than 65 years		Chronic anticonvulsant therapy
		Low trauma vertebral compression fracture		Low dietary calcium intake
		Low trauma fracture over age 40		Smoking
		Family history of osteoporotic fracture		Excessive alcohol intake
		Current glucocorticoid therapy greater than 3 mos		Excessive caffeine intake
		Malabsorption syndrome		Weight less than 57kg
		Primary hyperparathyroidism		Chronic heparin therapy
		Hypogonadism		Rheumatoid arthritis
		Early menopause (before age 45)		Human Immunodeficiency Virus (HIV) Medication
		Prostate Cancer		
		Breast Cancer		
		Medroxyprogesterone acetate injection (Depo provera)		

Ordering physician (please print)	Name		Signature	
	Fax #			
Copy of reports to be sent to:	Name		Name	
	Fax #		Fax #	

Health card must be provided at time of examination

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