



BRANT COMMUNITY HEALTHCARE SYSTEM  
**BONE MINERAL DENSITY (BMD) REQUISITION**  
 200 Terrace Hill St., Brantford ON N3R 1G9  
 Tel: 519-751-5599 Fax: 519-751-5582

**For Office Use Only:**  
 Appointment Date/Time:

Referring Clinician Information		Patient Information	
Name:	Health Card	Version	DOB
OHIP Billing Number:	First Name:	Last Name:	
Address	Address:		
City/Prov:	Postal Code:	City/Province:	Postal Code:
Phone:	Fax:	Phone Number:	Secondary Phone Number:
Signature:	WSIB Claim #:	Secondary Insurance:	
Copies to:	Patient Height:	Patient Weight:	

Does Patient Require Assistance?  Mechanical Lift  Wheelchair  Language Interpreter - Specify:

**BY APPOINTMENT ONLY \*\*INCOMPLETE REQUISITIONS WILL BE RETURNED\*\***

Baseline                       Low Risk                       High Risk  
 • High Risk = 1 major or 2 minor risk factors or previous BMD evidence of osteoporosis, osteopenia or >1% bone loss/year.

Major Risk Factors	Minor Risk Factors
<input type="checkbox"/> Age greater than 65 years <input type="checkbox"/> Low trauma vertebral compression fracture <input type="checkbox"/> Low trauma fracture over age 40 years <input type="checkbox"/> Family history of osteoporotic fracture <input type="checkbox"/> Current glucocorticoid therapy greater than 3 months <input type="checkbox"/> Malabsorption syndrome <input type="checkbox"/> Primary hyperparathyroidism <input type="checkbox"/> Hypogonadism <input type="checkbox"/> Early menopause (before age 45) <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Medroxyprogesterone acetate injection (Depo Provera)	<input type="checkbox"/> Chronic anticonvulsant therapy <input type="checkbox"/> Low dietary calcium intake <input type="checkbox"/> Smoking <input type="checkbox"/> Excessive alcohol intake <input type="checkbox"/> Excessive caffeine intake <input type="checkbox"/> Weight less than 57kg <input type="checkbox"/> Chronic heparin therapy <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Human Immunodeficiency Virus (HIV) Medications

**CLINICAL HISTORY: REASON FOR ORDER**

*(This area is currently blank for clinical history.)*

Previous Surgeries: \_\_\_\_\_ Current Medications: \_\_\_\_\_

Related Previous Imaging:  Yes  No If yes, please attach previous if not completed at BGH.

Please include all relevant patient history including previous reports or consult notes as appropriate.