

REQUISITION for BONE MINERAL DENSITY TESTING

Required information is indicated with an "*" and must be completed or the request will be declined.

Failure to sign this request will delay patient care.

(clerical use only) EPR Visit #:

| BMD TESTING LOCATIONS | PATIENT INFORMATION |
|--|---|
| St. Boniface General Hospital | *Last/First Name: (per Health Card) |
| Bone Density and J. P. Maclean Osteoporosis Centre | *DOB (dd/mm/yyyy) *Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| 408 - 400 Tache Avenue, Winnipeg, MB R2H 3C3 | MHSC: *PHIN: |
| Phone (204) 237-2756; FAX (204) 237-4195 | Full Address: |
| Brandon Regional Health Centre | Email Address: |
| Department of Nuclear Medicine / Bone Density | *Daytime Phone: () Mobile: () |
| G149 - 150 McTavish Avenue E., Brandon, MB R7A 2B3 | Emergency Contact / Next of Kin: _____ |
| Phone (204) 578-4325; FAX (204) 578-4986 | Translator <input type="checkbox"/> Language Required: _____ |

*SELECT ALL APPLICABLE REASONS FOR TESTING:

- Vertebral low-trauma fracture proven by x-ray (*Attach x-ray report if not on eChart*)
- Non-vertebral fracture proven by x-ray (*Attach x-ray report if not on eChart*)
- Osteopenia or osteoporosis identified on x-ray
- Systemic glucocorticoid therapy for more than 3 months in the last year
- Aromatase inhibitor therapy for breast cancer
- Prolonged amenorrhea, surgical menopause or premature menopause prior to age 45
- Woman age 70 or older (screening in men is not approved unless additional risk factors are provided below)
- Age 65-69 with one risk factor, age 50-64 with two or more risk factors, see reverse (*List relevant risk factors below*)
- Follow up of a previous bone density measurement (recommended initial interval 3 years for most patients, at least 5 years if previously reported as low risk, at least 2 years in patients on systemic glucocorticoid therapy or aromatase inhibitors)

Date of previous test: _____ Location of previous test: _____

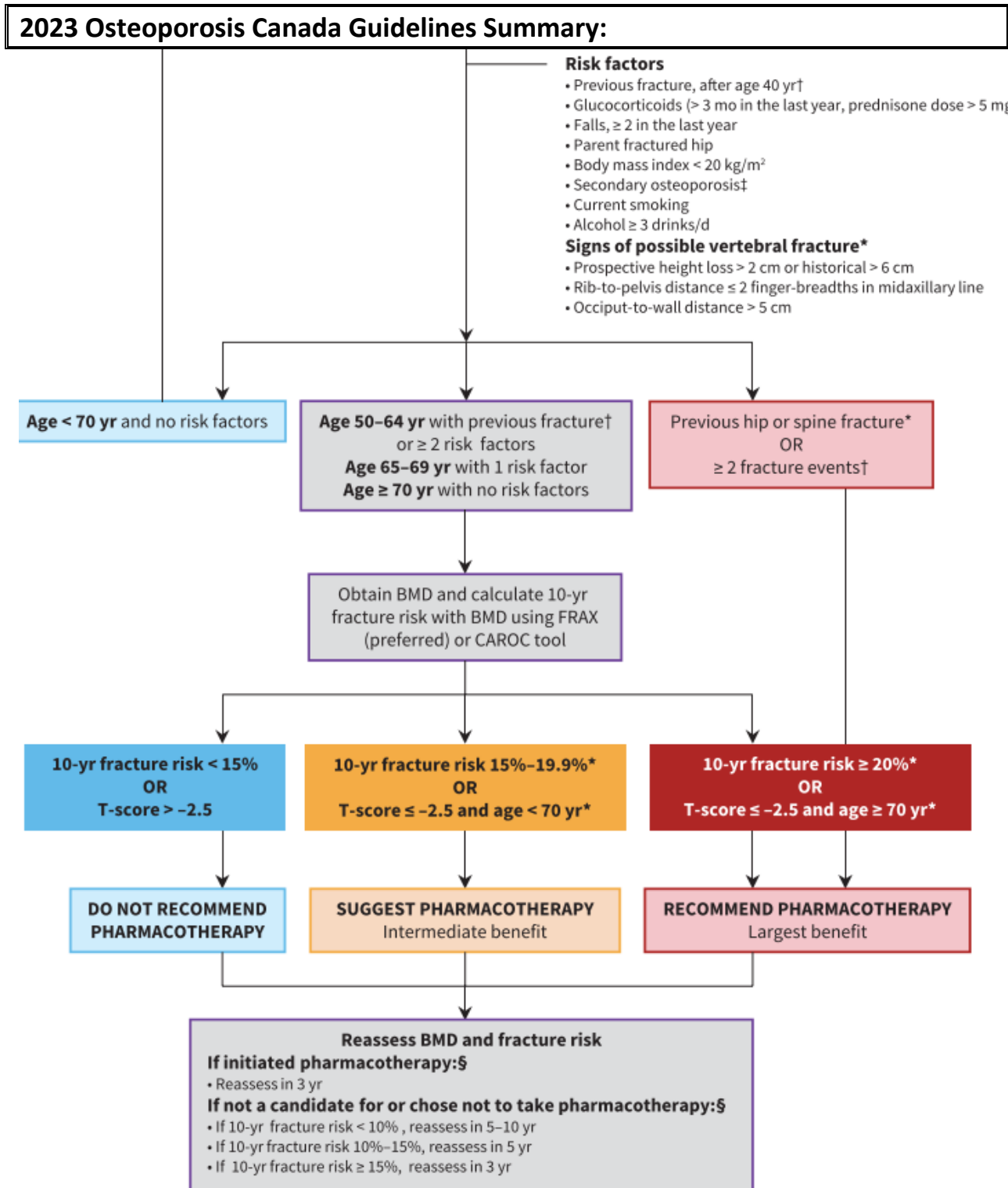
Other indications **may** be considered if appropriate clinical justification is provided:

ORDERING PROVIDER INFORMATION

| | | | |
|------------------------|-------------------------------------|---------------|-----------|
| _____ | _____ | _____ | () _____ |
| *Provider Signature | *Provider Name (print first & last) | Billing # | Fax # |
| _____ | _____ | _____ | _____ |
| Address | Phone # | *Date Ordered | |
| _____ | _____ | () _____ | () _____ |
| Copy to: Provider Name | Location | Fax # | Phone # |

FOR DEPARTMENT USE ONLY:

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From: Clinical practice guideline for management of osteoporosis and fracture prevention in Canada: 2023 update; <https://www.cmaj.ca/content/195/39/E1333>