

## BONE MINERAL DENSITY REQUEST FORM

When is scan required: \_\_\_\_\_

Date of next review: \_\_\_\_\_

Patient Details	Patient Contact Details
Surname _____	Home phone number _____
First name _____	Mobile phone number _____
Date of birth _____	Email address _____
Austin UR _____	Alternative contact person _____
Address _____	Phone number _____
Suburb _____	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	<b>Patient status:</b> <input type="checkbox"/> Public <input type="checkbox"/> DVA <input type="checkbox"/> Private <input type="checkbox"/> TAC <input type="checkbox"/> Overseas patient <input type="checkbox"/> Workcare
Ambulance transport <input type="checkbox"/> Yes <input type="checkbox"/> No <small>*Must notify in advance otherwise cancellation may result</small>	

### Referral Information

- Rebatable items** (please tick)
- Spine / hip or other fractures with minimal trauma
  - Patient age 70 or over
  - Osteoporosis diagnosed previously
  - Specific treatment for osteoporosis
  - Long term corticosteroid therapy (oral 7.5mg or inhaled >800µg/day)
  - Malabsorption ± including subnormal level of circulatory vitamin D
  - Diseases:  Chronic renal disease  
(Please tick)  Chronic liver disease  
 Hyperparathyroidism  
 Hyperthyroidism  
 Cushings syndrome
  - Male hypogonadism
  - Female hypogonadism lasting more than 6 months before the age of 45

**Clinical Details:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

**Patient mobility requirements:**  
Weight over 150kg?  Requires a hoist lift?

### Requesting Doctor & Report Distribution

Referring Doctor _____	Provider No. _____
Mobile _____	Signature _____
Email address _____	Date _____
Preferred mechanism of electronic transfer of report: HealthLink <input type="checkbox"/> Medinexus <input type="checkbox"/> Other: _____	

Additional copy of report to \_\_\_\_\_

Email address \_\_\_\_\_

Preferred mechanism of electronic transfer of report: HealthLink  Medinexus  Other: \_\_\_\_\_

Patients are free to take their referral to a diagnostic imaging provider of their choice. Please discuss with your doctor first. Request forms may be downloaded from <http://www.austin.org.au>

*Prof Andrew Scott MD, FRACP, DDU; Prof Christopher Rowe MD, FRACP; Dr Sam Berlangieri FRACP; Associate Prof Sze Ting Lee PhD, FRACP; Dr Aurora Poon FRACP; Dr Andrew Tauro FRACP; Dr Raef Boktor MD, FRACP, DDU; Dr Robin Low FRACP, DDU; Associate Prof Eddie Lau FRACP.*