

DEXA Bone Density Scan Request Form

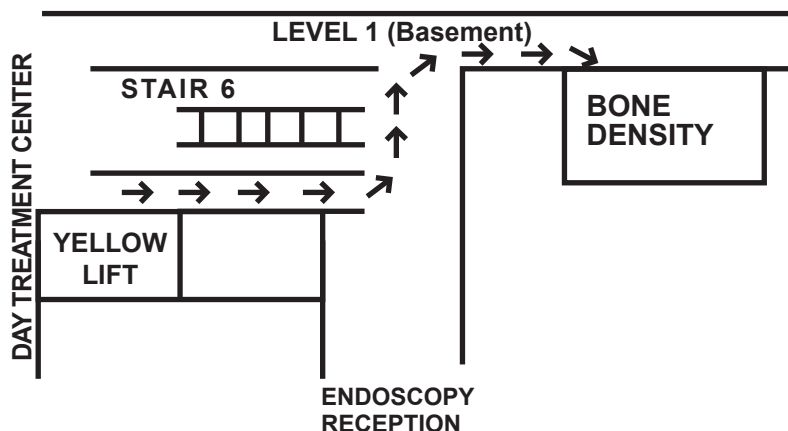
I dentify	Patient Name _____ DOB: _____ M / F Address: _____ Phone: _____ Mobile: _____ (Affix Patient's ID label here)	Is an interpreter required Y <input type="checkbox"/> Language <div style="border: 1px solid black; padding: 5px; text-align: center; width: 100%;"> Cubicle / Ward / Other Unit </div>	MI Use only Appt Date & Time _____ <input type="checkbox"/> Public <input type="checkbox"/> Medicare Elect																				
	Referring Medical Practitioner Details (Print) Name Provider number: Pager No Fax No Phone No Mobile Address: Additional Copy of Report to: Fax No																						
S ituation	Clinical Details Reason for Bone Density Scan: <input type="checkbox"/> 1. Confirmation of presumed low bone mineral density (BMD) (post-minimal trauma fracture) OR Monitoring of DEXA-proven low bone mineral density >24 months ago (Item 12306) <input type="checkbox"/> 2. Diagnosis and monitoring of bone loss associated with steroid therapy, excess glucocorticoid secretion, male/female hypogonadism >12 months ago (Item 12312) <input type="checkbox"/> 3. Diagnosis and monitoring of bone loss associated with primary hyperparathyroidism, chronic liver disease, chronic renal disease, malabsorption disorder (increased faecal fat, proven coeliac disease, low vitamin D), rheumatoid arthritis, thyroxine excess >24 months ago (Item 12315) <input type="checkbox"/> 4. 12 months post-significant change (but not cessation) in drug therapy for low BMD or presumed low BMD post-minimal trauma fracture (Item 12321) <input type="checkbox"/> 5. Aged >70 years (initial screening or every 5 years) (Item 12320) <input type="checkbox"/> 6. Aged >70 years (T-score -1.5 to -2.5 every 2 years) (Item 12322) <input type="checkbox"/> 7. Total Body (TB) Body Composition - Please specify reason in clinical notes below																						
	<ul style="list-style-type: none"> Unless assigned an above MBS item number, or an approved trial patient, you will incur a charge Safe weight limit for DEXA machine is 159 kgs, above this weight only forearm measurements are provided 																						
B ackground	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Patient Mobility</th> <th style="width: 30%;">Sites</th> <th style="width: 30%;">If patient < 17 yo, please state</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Walking <input type="checkbox"/> IV fluid attachment <input type="checkbox"/> Wheelchair <input type="checkbox"/> Trolley </td> <td style="padding: 5px;"> <input type="checkbox"/> Hip <input type="checkbox"/> Spine <input type="checkbox"/> Forearm <input type="checkbox"/> Total body </td> <td style="padding: 5px; vertical-align: top;"> SKELETAL BONE AGE: TANNER SCORE: </td> </tr> </tbody> </table>			Patient Mobility	Sites	If patient < 17 yo, please state	<input type="checkbox"/> Walking <input type="checkbox"/> IV fluid attachment <input type="checkbox"/> Wheelchair <input type="checkbox"/> Trolley	<input type="checkbox"/> Hip <input type="checkbox"/> Spine <input type="checkbox"/> Forearm <input type="checkbox"/> Total body	SKELETAL BONE AGE: TANNER SCORE:														
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A ssessment	Scan results required by: <ul style="list-style-type: none"> I, the referring doctor, confirm that I am clinically managing the patient and that the diagnostic information is required for the management of this patient. I, the referring doctor, verify that this is the correct patient, correct side and site of imaging request. 																						
	_____ Signature of Consultant/Specialist			_____ Date																			
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Patient Name/RIS Label:

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DIRECTIONS TO BONE DENSITY, CLAYTON:

Enter the main hospital entrance (level 2) go straight ahead, turn left at the gift shop and go towards the X-ray department. Turn left again at the corridor before X-ray towards the lifts. Take **Yellow Lift** down to level 1 (Basement) or **Stairwell 6**. Follow arrow on the map to Bone Density. We are down the corridor on the right hand side.



PATIENTS ARE ADVISED NOT TO BRING ANY VALUABLES TO THEIR APPOINTMENT.

PLEASE BRING IN YOUR MEDICARE CARD

I offer to assign my right to benefits to the approved radiology practitioner who will render the requested radiology service(s) and any eligible radiologist determinable service(s) established as necessary by the practitioner.

Patient's signature..... Date/...../.....

Ref. No. Expiry date /.....

Monash Imaging Use Only

Safety Checklist

Pregnancy Check

N/A Patient states "NOT" pregnant? Confirmed
bHCG Value: (if applicable)

Patient ID Check

Correct Patient Please tick 3 Patient Identifiers before commencing examination
Full name DOB Address ID Bracelet Ward/Relative identified patient
Correct Procedure Yes No
(Patient verification & clinical history) Technologist

Your doctor has recommended you use Monash Health.
You may choose another provider but please discuss this with your doctor first.