Monash Health Imaging

DEXA Bone Density Scan Request Form

Monash Medical Centre
Basement - Level 1,
246 Clayton Road, Clayton 3168.
Ph: +61 3 9594 2200 E: dicentral@monashhealth.org

Identity

Patient Name
UR:
DOB: M / F
Address:

Phone:
Mobile:

(Affix Patient's ID label here)

Is an interpreter required Y ☐

Language .....

Cubicle / Ward / Other Unit

MI Use only
Appt Date & Time

☐ Public
☐ Medicare Elect

Referring Medical Practitioner Details

(Print) Name ..... **Provider number:** .....

Baret Role: ..... Fax No..... Phone No..... Mobile .....

Address: .....

Additional Copy of Report to: .....Fax No .....

Situation

Clinical Details

Reason for Bone Density Scan:

☐ 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)

☐ 2. Diagnosis and monitoring of bone loss associated with **steroid therapy, excess glucocorticoid secretion, male/female hypogonadism >12 months ago** (Item 12312)

☐ 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)

☐ 4. **12 months post-significant change** (but not cessation) in **drug therapy for low BMD** or p**resumed low BMD** post-minimal trauma fracture (Item 12321)

☐ 5. **Aged >70 years** (initial screening or every 5 years) (Item 12320)

☐ 6. **Aged >70 years** (T-score -1.5 to -2.5 every 2 years) (Item 12322)

☐ 7. **Total Body (TB) Body Composition** - Please specify reason in clinical notes below

Background

- **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

Patient Mobility		Sites	If patient < 17 yo, please state
☐ Walking	☐ IV fluid attachment	☐ Hip	
☐ Wheelchair	☐ Trolley	☐ Spine	SKELETAL BONE AGE:
		☐ Forearm	TANNER SCORE:
		☐ Total body	

Assessment

Clinical Notes (or if no MBS item number) STUDY NAME / MEDICATION NAME:

Request

Scan results required by: .....

- 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*

CLAYTON	DANDENONG	CASEY	MONASH CHILDREN'S HOSPITAL CLAYTON	MOORABBIN	KINGSTON	VICTORIAN HEART HOSPITAL	PAKENHAM HEALTH CENTRE
Monash Health Imaging all sites: 9594 2200							
Email: dicentral@monashhealth.org	Email: dhimaging@monashhealth.org	Email: cimaging@monashhealth.org	Email: mchimaging@monashhealth.org	Email: mimaging@monashhealth.org	Email: mimaging@monashhealth.org	Email: vhhimaging@monashhealth.org	Email: ciimaging@monashhealth.org

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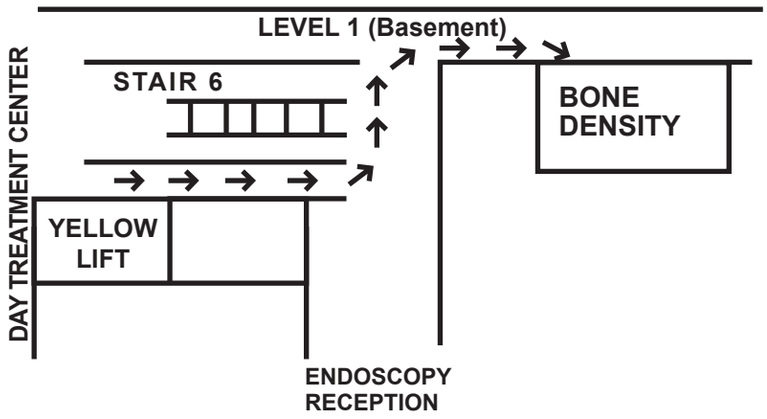
DIRECTIONS TO BONE DENSITY, CLAYTON:

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.