MASSACHUSETTS GENERAL HOSPITAL – BONE DENSITY TEST (DXA) REQUISITION

BONE DENSITY CENTER, 10 EMERSON PLACE, SUITE ONE, BOSTON, MA 20114

Patient Name (Last, First):

Patient Date of Birth (MM/DD/YYYY):

Ordering MD:

Ordering MD Telephone number:

Ordering MD Fax number:

Ordering Provider Signature: Date:

1. INDICATE PURPOSE OF DXA (SCREENING OR MONITORING):

☐ SCREENING DXA: (select at least ONE box, must be known diagnoses and NOT rule/out)

- ☐ Menopausal
- ☐ Postmenopausal
- ☐ Estrogen deficiency
- ☐ Ovarian failure due to treatment
- ☐ Premature ovarian failure
- ☐ Testicular hypofunction
- ☐ Fractures
- ☐ Vitamin D deficiency
- ☐ Primary hyperparathyroidism
- ☐ Undergoing drug treatment with steroids
- ☐ Intestinal malabsorption
- ☐ Disorder of calcium metabolism
- ☐ Anorexia nervosa
- ☐ Osteogenesis imperfecta
- ☐ Thyrotoxicosis
- ☐ Renal osteodystrophy
- ☐ Cushing's syndrome

☐ MONITORING DXA: (select at least ONE box, must be known diagnoses and NOT rule/out)

☐ Osteopenia ☐ Osteoporosis ☐ Cushing's Syndrome

2. EXAM REQUESTED (Pick only ONE of the following)

- ☐ DXA Spine + Hip only
- ☐ DXA Forearm only
- ☐ DXA Spine + Hip + Forearm
- ☐ DXA Spine + Whole body (ONLY for pediatric patients who are actively growing)

Please note that DXA scans should not be performed for 1 week following any barium exam (Barium swallow, barium enema, abdominal CT) or nuclear exam (bone scan, PET, thyroid).

FAX TO (617) 724-0696. FOR QUESTIONS, CALL (617) 726-3839