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 ☐ Undergoing drug treatment with steroids
☐ Estrogen deficiency ☐ Intestinal malabsorption ☐ Disorder of calcium metabolism
☐ Ovarian failure due to treatment ☐ Anorexia nervosa ☐ Osteogenesis imperfecta
☐ Premature ovarian failure ☐ Testicular hypofunction ☐ Thyrotoxicosis
☐ Fractures ☐ Vitamin D deficiency ☐ Renal osteodystrophy
☐ Primary hyperparathyroidism ☐ 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 Spine + Whole body (ONLY for pediatric patients who are actively growing)
☐ DXA Forearm only
☐ DXA Spine + Hip + Forearm

**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