CESHA
Centre of Excellence in Skeletal Health Assessment

Office Use Only:
Date Rec'd: _____

Appt Date & Time: _____

Bone Mineral Density Requisition

Patient Information			
Patient Name:			**DOB (dd/mmm/yyyy)**
Address:	**City**	**Province**	**Postal Code**
Phone number:	**Alternate number:**	**OHIP:**	

Previous BMD test? ☐ No This request is a baseline test

☐ Yes **When?** _____

Where? ☐ Mount Sinai ☐ Princess Margaret ☐ Toronto General ☐ Toronto Western

☐ TRI Lyndhurst ☐ Other _____

Is patient considered High Risk by OHIP guidelines?

☐ Yes. Patient with an expected bone loss in excess of 1% per year

☐ No. Low risk. OHIP will cover 2nd BMD after 3 years from baseline and successive BMD (3rd scan or more) is covered 5 years from the last scan.

☐ Not OHIP covered. Patient will pay for the scan.

Does the patient require a lift? ☐ No ☐ Yes

Does the patient have hyperparathyroidism or need 2nd site to scan (can't scan either hip or spine)? ☐ No ☐ Yes, add forearm BMD scan

Has patient had a previous fracture as an adult? ☐ No ☐ Yes, specify _____

Did the patient's parent fractured their hip? ☐ No ☐ Yes, ☐ Mother ☐ Father

Is patient taking oral glucocorticoids? ☐ No ☐ Yes

Does patient have Rheumatoid arthritis? ☐ No ☐ Yes

Relevant Medical History, risk factors: _____

Referring Physician Information:

Name: _____ **OHIP Billing no.:** _____

Address: _____

Tel: _____ Fax: _____

Signature: _____ **Date:** _____

Please fax referral to the CESHA Program:
UHN: 416-340-4707
MSH: 416-586-8790
TRI: 416-597-7042
For questions, please call
UHN: 416-340-3890
MSH: 416-586-4446
TRI: 416-597-3422 ext. 6591