



**Healthy Bones Unit**    **Bone Mineral Densitometry Request Form**  
Director:                    **Dr. F.J. Cameron**    Department of Endocrinology and Diabetes  
Associate Consultant:    **Dr. M. Zacharin**    9th Floor, RCH.                    Bookings: 9345 5951

UNIT \_\_\_\_\_ WARD/CLINIC \_\_\_\_\_

CONSULTANT \_\_\_\_\_

Region(s) to be examined: (please tick)

Whole body     Hip     Lumbar spine     Other \_\_\_\_\_

Previous Studies (please tick)     Yes     No

When: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Place \_\_\_\_\_

IS THE PATIENT PREGNANT?     Yes     No

BONE AGE (if known): \_\_\_\_\_

RELEVANT CLINICAL DATA: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

INDICATION FOR BONE MINERAL ASSESSMENT (Please tick):

- MBS Item No 12306
  - MBS Item No 12312
  - MBS Item No 12315
  - MBS Item No 12321
  - Other indication (Please specify) \_\_\_\_\_
- }    Defined overleaf

AFFIX PATIENT ID LABEL HERE OR PRINT DETAILS

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_ SEX \_\_\_\_\_ DOB \_\_\_\_\_

UR NO. \_\_\_\_\_ CATEGORY \_\_\_\_\_

Was or will the patient be at the time of the service:

a private patient in a private hospital

or approved day facility?                     Yes     No

a private patient in a recognised hospital?                     Yes     No

a hospital patient in a recognised hospital?                     Yes     No

an outpatient in a recognised hospital?                     Yes     No

REQUESTED DOCTOR

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE \_\_\_\_\_

PROVIDER NO. \_\_\_\_\_ DATE \_\_\_\_\_