PIEDMONT ARTHRITIS CLINIC, P.A.

RHEUMATOLOGY

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BONE MINERAL DENSITY REFERRAL FORM

PATIENT INFORMATION LAST NAME:_____ FIRST NAME:_____

ADDRESS: _____ CITY: _____ STATE:____ ZIP_____

HOME PHONE: _____ CELL PHONE: _____ DOB: _____

INSURANCE: _____ (Please attach copy of insurance card)

REFERRING PROVIDER LAST NAME: _____ FIRST NAME:_____

MD DO NP PHONE:_____ FAX:_____ CONTACT:_____

MEDICARE GUIDELINES ALLOW SCREENING OF BMD ONCE EVERY TWO YEARS (AT LEAST 23 MONTHS HAVE PASSED SINCE THE MONTH THE LAST COVERED BMD WAS PERFORMED

SERVICE REQUESTED (PLEASE CHOOSE ONE)

_____ BASELINE SCREENING FOR OSTEOPOROSIS

_____ COMPARISON SCAN TO MONITOR BMD AND/OR TREATMENT RESPONSE

CLINICAL INDICATIONS (SELECT ANY THAT APPLY)

_____ POSTMENOPAUSAL _____ ESTROGEN DEFICIENT _____ FRAGILITY FRACTURE

_____ OSTEOPOROSIS _____ OSTEOPENIA _____ FAMILY HISTORY

_____ PRIMARY HYPERPARATHYROIDISM _____ CURRENT GLUCOCORTICOID THERAPY

_____ MONITOR DRUG THERAPY

OTHER: _____

SPECIAL INSTRUCTIONS: _____

_____

PLEASE FAX REFERRAL FORM AND APPLICABLE MEDICAL RECORDS TO 864-271-4092