Bluewater Health

Department of Diagnostic Imaging

89 Norman Street
Sarnia, ON N7T 6S3
Phone 519 464-4433 Fax 519 383-8536

☐ In Pt & floor ____________ ☐ Out Pt

Patient Name ____________

Address ____________

____________ Postal Code ____________

Phone: Home ____________ Work ____________

D.O.B. ____________ (DD/MM/YYYY) Sex ☐M ☐F

Bone Mineral Densitometry

Please complete the following patient information.
Incomplete requests will be returned resulting in a delay of this procedure.

Health Card No. ____________ VC ____________

Type of BMD exam: ☐**Baseline** ☐**Routine** ☐**High Risk**

Date of last BMD exam ____________ (DD/MM/YYYY) completed at ____________

List osteoporosis risk factors ____________

____

____

____

____

____

Physician, please **Fax** this request to the Imaging scheduling office at 519 383-8536 for processing.
Patient may present this request, in person, at the Imaging scheduling office located at the Norman site, Maria Street entrance.

____________ ____________

Ordering Physician Signature (please also print name) Date (DD/MM/YYYY)

____________ ____________

Family Physician (please print name) **Copy to Physician** (please print name)

For Imaging Department use only Date Due ____________ (DD/MM/YYYY)

Appointment Date ____________ (DD/MM/YYYY) at ____________ hrs. Code ____________ DoL ____________ (DD/MM/YYYY)