|  |  |
| --- | --- |
|  | Fax completed requisition to: DXA Center/Kim Mitchell (617) 730 – 0020  Scheduling – (617) 355 - 3789 |
| **(DXA) DUAL ENERGY X-RAY ABSORPTIOMETRY  REQUEST FORM**  Reason for DXA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diagnosis (select from following list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | USE STICKER OR PRINT  MR #:  Patient Name:  Date of Birth: |
| Previous DXA Scan at BCH: Yes No  Does Patient Require Oxygen: Yes No  Does Patient have a Ventilator: Yes No  Is Mobility Assistance Needed: Yes No  Does Patient have Orthopedic Hardware: Yes No  Orthopedic hardware location? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is prescribed estrogen/testosterone? E. T. None | Appt scheduled through referring clinic  Patient/Family will call to schedule  DXA Center should call to schedule  Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Examination Requested:**  **STANDARD EXAMINATION (please check a box below)**   * Initial DXA scan at BCH, no spine or hip hardware   4-15 years old: total body and spine  16 years old or older: hip and spine  Body Composition   * Prior DXA scan at BCH, no spine or hip hardware   4-15 years old: total body and spine  One-time transition for patients with prior “4-15 years old TB/spine” 🡪 now “16+ years old Hip/Spine”: total body, spine, hip  16 years old or older: hip and spine  Body Composition   * **SPECIAL CIRCUMSTANCES:**  If unable to obtain standard scans (due to hardware, inability to hold still, etc.), consider the following in children >4 years, with a goal to obtain two sites:   + - Hip (unless hip hardware is present)     - and either…     - Distal lateral femur     - Forearm   **NOTE: Height-adjusted Z-scores will be provided for patients <5th %ile**  Bone Age Adjustment - Only if concerned for delayed bone age without short stature, consider requesting a bone age adjusted DXA. There are more accurate normative data for height adjusted DXA scans.  Results will be sent to referring physician within 7 -10 days  REQUESTED BY:  (SIGNATURE) MD / PNP    (PRINTED NAME) MD / PNP | |

Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

