Dartmouth-Hitchcock
MEDICAL CENTER

Department of Radiology
Phone: (603) 653-9388
Please fax request to:
Fax: (603) 650-0380

Referral Form
Bone Density Study (DXA)

Today's date: _____ Date of service: _____ Time of service: _____

Patient's name: _____

MRN: _____ DOB: _____

Mailing address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Medicare: ❑ Primary ❑ Secondary Current Height: _____ Current Weight: _____ lbs

Date of last DXA scan: _____

Patient's special needs: _____

Clinical history: _____

_____

Pediatric indications: _____

_____

Requesting provider: _____

Office phone: _____ Office fax: _____

Address: _____

Staff physician: _____

Office phone: _____ Pager #: _____

Medicare/ non-Medicare Insurance Covered Indications

Medicare patients only: at least 24 months must have passed since the last bone mass measurement was performed. Any sooner will need an Advanced Beneficiary Notice (ABN) signed.

All insurances including Medicare must meet one or more of the covered indications (check all that apply):

- ❑ A woman who is estrogen deficient or at clinical risk for osteoporosis based on medical history and other findings.
- ❑ A person with vertebral abnormalities on x-ray suggesting osteoporosis, low bone mass or vertebral fractures.
- ❑ A person with primary hyperparathyroidism.
- ❑ A person receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 5mg of prednisone, or greater, per day, for more than 3 months.
- ❑ A person being monitored to assess the response to FDA-approved osteoporosis drug therapy such as: Actonel, Boniva, Fosamax, Evista, Calcimar, Calcitonin, Miacalcin
- ❑ *Other indications (ABN/waiver needed): _____

*If a Medicare patient does not meet at least ONE of the above indications, you MUST have a signed ABN/waiver of payment at the time of scheduling, indicating the understanding that services may not be covered. ABN/waiver must be signed and faxed with the request to (603) 650-0380.

Secretary: _____ Phone/ext: _____

Requesting provider signature (required): _____