Gillette Children's
Specialty Healthcare

To schedule call: 651-229-3995
Please complete and fax to: 651-265-7480

Patient Name: _____ Date of Birth: _____

Parent / Guardian: _____ Phone Number: _____

Appt. Preference: ☐ Today ☐ Within 1 week ☐ Specify, within: _____ weeks/months

Reason for Exam / Medical Necessity / Symptoms & Duration: _____

Dx (All indications): _____

Reason for DXA Exam:	Pediatric 3-19 years old	Adult over 19 years old
	☐ Fracture History	☐ Risk factors for fracture
☐ Initial ☐ Follow-Up	☐ Chronic immobilization	☐ Prior fractures
	☐ Malnutrition	☐ Vertebral fracture
	☐ Bone, active treatment	☐ Low body weight
	☐ Chronic inflammatory disease	☐ Hyperparathyroidism
	☐ Endocrine disturbance	☐ Post menopausal
	☐ History of childhood cancer or transplant	☐ Disease/condition associated with low bone mass or bone loss
	☐ Prior steroid use	☐ Prior steroid use
	☐ High risk medication use	☐ High risk medication use
	☐ Monitor for treatment effect	☐ Monitor for treatment effect

Does the patient have any hardware? ☐ NO

☐ YES, location: _____

Needed for complete bone density assessment:

Tanner Stage:	**I**	**II**	**III**	**IV**
Breast Development				
Male Genitalia				
Pubic Hair				

Bone Age _____ at Chronological Age _____

Provider Name: _____ **Signature:** _____ **Date**: _____
Print/ Stamp here

Phone Number: _____ **Address:** _____

8083-960
01/11

Outside Provider Bone Densitometry (DXA) Order