ADVANCED BONE HEALTH SERVICES INC.

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BONE SCAN REQUISITION FORM

This **Bone Scan Requisition Form** is designed to streamline the referral process by collecting essential patient and clinical information prior to scheduling the scan. **Please ensure all required fields are completed** to facilitate a smooth and efficient assessment.

PATIENT INFORMATION:

Patient Full Name: Patient email:

Patient Phone #: Sex: Male ☐ Female ☐ Other ☐

Date of Birth (DD/MM/YYYY):

Patient Weight (kg): Patient Height (cm):

REFERRING PHYSICIAN INFORMATION:

Physician Name: Physician Number:

Clinic/Hospital Name:

CLINICAL INDICATION (REASON FOR SCAN):
Select all that apply:
☐ First-time Bone Scan
☐ 6-Month Follow-Up
☐ 1-Year Follow-Up

RELEVANT CLINICAL HISTORY:
Primary Diagnosis/Suspected Condition:
_____
Previous Bone Scans? ☐ Yes ☐ No If yes, date: _____ / _____ / _____
History of Cancer? ☐ Yes ☐ No If yes, type: _____
History of Fractures? ☐ Yes ☐ No If yes, location & date: _____
Previous Surgeries/Implants? ☐ Yes ☐ No If yes, details: _____

ECHOLIGHT BONE SCAN
Please select the type of scan needed:
☐ Bone Density Scan
☐ Bone Fragility Index

CURRENT MEDICATIONS:
Please list any current medications:
• Bisphosphonates (e.g., Fosamax, Actonel, Boniva):

_____

OTHER MEDICATIONS:

_____

ADDITIONAL NOTES/SPECIAL INSTRUCTIONS:

_____

_____