UMASS MEMORIAL MEDICAL CENTER DEPARTMENT OF RADIOLOGY

NUCLEAR MEDICINE / BONE DENSITY REQUISITION FORM

University Campus

Memorial Campus

55 Lake Avenue North 119 Belmont Street Scheduling: 508-334-5813

Fax:

774-443-4472

Scheduling: 508-334-5813

NAME:

ADDRESS:

BIRTHDATE/AGE:

SEX:

MEDICAL RECORD NUMBER:

PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD

Clinical Indication for Exam: (R/O is NOT ac	cceptable, must include signs, symp	toms, DX) Wet Read, ca	ll to:	
Hip and Spine Only: Forearm: Left	_ Right			
Previous Bone Density Date:	Location:			
Patient Home #:	Patient Work #:	Patient Cell #	# :	
Send Reports To:				
Patient Pregnant? Yes No	Allergies:	Height: Preferred La	Weight: nguage:	
INSURANCE:	PRE-AU	JTHORIZATION:		
	MUSCULOSKELETAL S	YSTEM		
If Medica	re of Tufts, you must select one of t	ne following options below.		١
☐ Vertebral Abnormality on X-Ray or Bone	Density of spine to be indicative of O	steoporosis, Osteopenia (lov	v bone mass) or	vertebral fracture
☐ Assess efficacy of FDA approved Osteo	porosis drug therapy			
Receiving or expecting to receive glucoo	corticoid (steroid) therapy 5mg or hig	pher for 3 months or longer		
Estrogen Deficient and at clinical risk for	Osteoporosis based on medical fin	dings		
☐ Known Primary Hyperparathyroidism				
Frequency Requirements: Medicare provice 2 years (i.e., at least 23 months after the last may provide coverage for a beneficiary more measurements may be medically necessary in glucocorticoid (steroid) therapy of more than future if certain specified requirements are more managements.	t covered bone mass measurement frequently than every 2 years. Exa- nclude, but are not limited to, the follo 3 months; or allowing for confirmato	was performed). Note: If me mples of situations in which owing medical conditions: mo ory baseline bone density st	edically necessa more frequent to poitoring patients	ry, Medicare cone mass s on long-term
Medicare does not cover Bone Density So	creenings.			
Other insurances: Any questions regarding coverage need to g	o directly to each individual insurand	ce plan for clarification.		
Ordering Provider (MD/PA/NP) Signature	Printed Name	Pager/Tel	Date	Time

