



Bone Densitometer Unit
Gynaecology Out-Patients
Mater Dei Hospital

Helpdesk: 25457000
e-mail: bonedensity.mdh@gov.mt

REQUEST FOR BONE DENSITY MEASUREMENT

Name: _____ Surname: _____	
Address: _____	
ID Card No: _____	Age: _____ Tel/Mob: _____
Country of Origin: _____	Primary/Secondary Care: _____
Clinical Indication: _____	
Gender <input type="checkbox"/>	Weight <input type="checkbox"/> kg
Height <input type="checkbox"/> cm	BMI <input type="checkbox"/>
History of Previous Fracture ¹ <input type="checkbox"/>	Site _____ Year _____
Family history of hip fracture <input type="checkbox"/>	(If Yes , _____)
Tobacco smoking <input type="checkbox"/>	(If Yes , number daily _____)
Alcohol (>3units daily) <input type="checkbox"/>	
History of glucocorticoid use ² <input type="checkbox"/>	
Secondary Osteoporosis <input type="checkbox"/>	
Confirmed Rheumatoid arthritis <input type="checkbox"/>	
FRAX Score 10 year probability of major osteoporotic fracture	<input type="text"/>
10 year probability of hip fracture	<input type="text"/>
Current Treatment: _____	
Calcium & Vit D: _____	Other: _____
Antiresorptive Treatment: _____	
Doctor requesting Test: _____	Medical Register No: _____
Signature: _____	Date: _____
Contact: Telephone _____	Mobile: _____
<i>All fields must be filled. Appointment will only be given if form is completed fully and legibly.</i>	
New case <input type="checkbox"/>	Follow-up <input type="checkbox"/>
Last done in <input type="text"/>	Repeat in <input type="text"/>

¹ A previous fracture denotes more accurately a fracture in adult life occurring spontaneously, or a fracture arising from trauma, which, in a healthy individual, would not have resulted in a fracture.
² Enter yes if patient is exposed to oral glucocorticoids or has been exposed to oral glucocorticoids for more than 3 months at a dose of prednisolone of 5mg daily or more (or equivalent doses of other glucocorticoids)