



## BONE DENSITY ORDERS

PATIENT

Date \_\_\_\_\_ Account # \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient \_\_\_\_\_  Male  Female PCP \_\_\_\_\_

**Patient Screening**

- |   | <u>Yes</u>               | <u>No</u>                |             |
|---|--------------------------|--------------------------|-------------|
| 1. Have you had a Dexa (Bone Density) scan in the last 2 years?             | <input type="checkbox"/> | <input type="checkbox"/> | When? _____ |
| 2. Are you on any treatment for osteoporosis?<br>If Yes, please list: _____ | <input type="checkbox"/> | <input type="checkbox"/> |             |
| 3. Are you postmenopausal or had a hysterectomy?                            | <input type="checkbox"/> | <input type="checkbox"/> |             |
| 4. Does your family have a history of osteoporosis or bone fractures?       | <input type="checkbox"/> | <input type="checkbox"/> |             |
| 5. Do you have a history of bone fractures?                                 | <input type="checkbox"/> | <input type="checkbox"/> |             |
| 6. Do you currently take or have you taken long term steroids?              | <input type="checkbox"/> | <input type="checkbox"/> |             |

PHYSICIAN

**Diagnosis Code**

- 733.00 – Osteoporosis, unspecified  
 256.31-256.39 – Premature menopause/other ovarian failure

**Procedure Code:**

- 77080 – Bone Density Study  76077 – Vert. Fx. Assessment

**Yes**    **No**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1) Has the patient had an x-ray that shows vertebral abnormalities that are indicative of Osteopenia, Osteoporosis, or a vertebral fracture? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2) Is the patient being monitored to assess the response to, or efficiency of an FDA approved Osteoporosis drug therapy?                     |
| <input type="checkbox"/> | <input type="checkbox"/> | 3) Has the patient been on steroid therapy for more than 3 months?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4) Has the patient had a Bone Density Study (77080) with-in the past 2 years?  |

**If YES to #4, please answer questions below. If NO, move to appointment date.**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 5) Is the test necessary to monitor the response to or efficacy of an FDA approved Osteoporosis drug therapy?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 6) Is the test necessary to determine a patient's response to pharmacologic therapy when the therapy has been changed to another family of therapeutic agents?                       |
| <input type="checkbox"/> | <input type="checkbox"/> | 7) Is the test necessary to monitor a patient receiving, or expected to receive, steroid therapy of 30 mg cortisone or 5.0 mg prednisone or greater per day, for more than 3 months? |

**OAWF Physician Standing Order**

Patient declines Dexa Scan

Per Physician, Dexa Scan not needed at this time

\_\_\_\_\_ Date

\_\_\_\_\_ Date

\_\_\_\_\_ Date

SECTION

**SCHEDULING AND AUTHORIZATION**

Appt. Date \_\_\_\_\_ Time \_\_\_\_\_ Insurance Carrier \_\_\_\_\_

Policy # \_\_\_\_\_ Phone # \_\_\_\_\_

Auth # \_\_\_\_\_ Benefits \_\_\_\_\_

**Radiology Department**

Date Scan Completed \_\_\_\_\_ Technologist \_\_\_\_\_ Documented in chart \_\_\_\_\_