**Osteoporosis Clinic**
**Toronto General Hospital**
**North Building, 7-718A**
**585 University Avenue**
**Toronto, ON M5G 2N2**
**Tel: (416) 340-4609**
**Fax: (416) 340-3750**

For Office Use Only:

Date Received: _____

BMD Date: _____

Appt. Date & Time: _____

# REQUEST FOR CONSULTATION

| | |
|---|---|
| | Date: |
| **PATIENT'S DEMOGRAPHIC INFORMATION** | |
| Last Name | First Name |
| Gender ☐M ☐F | DOB (dd/mm/yyyy) |
| Home Address | |
| Home Telephone Number: | Alternate Phone Number: |
| UHN MRN (if applicable): | OHIP: |
| Will an interpreter be required? ☐Yes ☐No | If yes, what language? |
| **REFERRING PHYSICIAN'S INFORMATION** | |
| Name: | |
| Address: | |
| Phone: | Fax: |
| OHIP Billing Number: | Signature |
| **FAMILY PHYSICIAN'S CONTACT INFORMATION (if different from above)** | |
| Name: | Address: |
| Phone: | Fax: |
| **DIAGNOSIS AND RELEVANT MEDICAL INFORMATION:** | |
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Has the patient undergone a bone mineral density (BMD) test within the last year? ☐Yes ☐No
If no, please arrange for the patient to have a BMD test. It is encouraged that BMD tests be booked using the same machine as the previous BMD test.

A current BMD with images **must** accompany this referral, unless a referral has been submitted to Centre of Excellence in Skeletal Health Assessment (CESHA). Call CESHA at (416) 340-3890 to book an appt.

**Please send all supporting documents, test results or investigations with this referral.**

Referrals will be triaged and scheduled based on a standard priority scale. Incomplete referrals will delay the booking process. The patient will be notified by phone regarding their appointment date and time.