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Diagnostic Imaging Center
مركز الأشعة التشخيصية

Patient's Label

Checklist and Consent Form for BMD Exam

Height	**cm**	**BMI**		**Age**	**Yrs**
Weight	**Kg**				

List of current medications:

	YES		YES		YES		YES
Anticonvulsants		Fosamax or Actonel		Multivitamin		Zolendronic (Zometa)	
Actonel (Risendronate)		Raloxifene hydrochloride (Evista)		Iron		Others:	
				Sodium Fluoride			
Calcium		Heparin		Steroids			
Calcitonin		Vitamin D		Tamoxifen			
Evista		Ibandronate (Bovina)		Thyroid Meds			
Estrogen		Lithium		Oral Glucocorticoids			

Have you had any x-ray procedures that used contrast / Nuclear medicine within last two weeks?

EXAM	YES	NO	EXAM	YES	NO	EXAM	YES	NO	Others:
Barium enema			CT Scan			Lung Scan			
IVU			MRI with contrast			Cardiac Scan			
Gastro Intestinal Series			Bone Scan			Thyroid Study			

For Diabetic patient with insulin pump:

	YES	*NO*	
Do you have infusion set			If (yes) Mention the location:
Do you have glucose sensor			If (yes) Mention the location:

For Females ONLY:

	YES	NO		YES	NO
Are you post-menopausal?	Age:		Were your ovaries removed?		
Have you had a hysterectomy?			Are you pregnant? If YES, state (LMP):		

Do you have any of the following listed conditions?

Major Risk Factors				Minor Risk Factors			
	YES		YES		YES		YES
Age > 60years		H/O Chronic bowel disease or malabsorption		Chronic glucocorticoid therapy		Any internal metal pins or plates implanted?	If yes, mention:
Early menopause before age 45years		Family history of osteoporosis		First degree relative		Any hip surgery?	If yes, mention:
						Parental hip fracture?	Yes / No
Known osteoporosis		Radiological osteopenia		Diabetes Mellitus Type2/ rheumatoid arthritis		Any broken bone?	If yes, mention:
Suspected osteoporosis		Bariatric surgery		Calcium and Vit. D deficiency		***Others***:	
Primary hyperthyroidism		Cushing's disease		Smoking			
Hypothyroidism		Hyperthyroidism		Alcohol intake			

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Diagnostic Imaging Center
مركز الأشعة التشخيصية

Patient's Label

Consent Form to Perform the Procedure
إقرار بالموافقةعلى اجراء الفحص

I agree to undergo BMD examination with full knowledge of the information that has been given to me about the IDEXA before starting the procedure.

أقر بموافقتي وبمعرفتي الكاملة للمعلومات التي أعطيت لي وإني قرأت محتوى هذا النموذج وعلى فهم بما يتضمنه، وقد أتيحت لي الفرصة للسؤال حول المعلومات الواردة في هذا النموذج وفيما يخص فحص كثافة العظام.

Signature of person completing form: _____

توقيع المراجع الذي قام بتعبئة النموذج: _____

Date_____/_____/_____

التاريخ_____/_____/_____

Form completed by: Patient/Relative (Name relationship to patient) _____

قام بتعبئة هذا النموذج أحد أقرباء المراجع (الاسم وصلة القرابة) _____

Tech.Name_____

إسم فني الأشعة_____