

Diagnostic Imaging Center

مركز الأشعة التشخيصية

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:	
Calcium		Heparin		Sodium Fluoride			
Calcitonin		Vitamin D		Steroids			
Evista		Ibandronate (Bovina)		Tamoxifen			
Estrogen		Lithium		Thyroid Meds			
				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:
Known osteoporosis		Radiological osteopenia		Diabetes Mellitus Type2/ rheumatoid arthritis		Parental hip fracture?	Yes No
Suspected osteoporosis		Bariatric surgery		Calcium and Vit. D deficiency		Any broken bone?	If yes, mention:
Primary hyperthyroidism		Cushing's disease		Smoking		Others:	
Hypothyroidism		Hyperthyroidism		Alcohol intake			

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Consent Form to Perform the Procedure

إقرار بالموافقة على إجراء 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 أتاحت 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 _____