Department of Radiology
Dartmouth-Hitchcock
MEDICAL CENTER

BONE DENSITY STUDY (DXA) REQUEST

Please complete and fax to: **(603)-640-1944**
For telephone assistance: **(603)-653-9388**

PATIENT INFORMATION

Patient Name:_____ DOB: _____/_____/_____

Medicare: ☐ Primary ☐ Secondary **Height**: _____ **Weight***: _____ lbs MRN:_____

☐ **Patient Ambulatory*** **Date of last DXA Scan***: _____/_____/_____

Special Considerations:

☐ Blind
☐ Deaf
☐ Diabetic
☐ Disoriented
☐ IV
☐ O^2
☐ Pregnant
☐ **Precautions**
☐ Stretcher Needed
☐ Wheelchair Needed

Patient Special Needs:_____

_____

_____

Clinical History:_____

_____

Pediatric Indication: _____

☐ Additional Trabecular Bone Scan (TBS) measurements? (Medicare does reimburse TBS. Additional charge may incur for other insurance coverage.)

INDICATION – CHECK ALL THAT APPLY (*Required)

***MEDICARE/NON-MEDICARE INSURANCE COVERED INDICATIONS:** At least 24 months **must** have passed since the last bone mass measurement was performed – Any sooner will require a signed ABN form)

All insurances including Medicare must meet one or more of the covered indications:

☐ Estrogen Deficient (E28.39)
☐ Hyperparathyroidism (E21.3)
☐ Osteopenia (M85.80)
Body Part*: ☐ Spine ☐ Forearm ☐ Hip ☐ Multiple Sites
Laterality*: ☐ Left ☐ Right ☐ Bilateral
☐ Osteoporosis
☐ Age related (M81.0)
☐ Medication Induced (M81.8)

☐ Other Indication**: ICD 10* _____ Code Description*:_____

**If a Medicare patient does not meet at least one of the above indications you MUST have a signed Advanced Beneficiary Notice (ABN)/waiver of payment at the time of scheduling, indicating the understanding that services may not be covered. ABN/Waiver must be signed and faxed with the request to 603-640-1944.

REFERRING PROVIDER

Ordering Facility Name: _____

Ordering Facility Phone #: (_____) - _____ - _____ Provider Pager: _____

Ordering Provider Name (Print): _____

Ordering Provider Signature*: _____ Date: _____/_____/_____

☐ Staff Physician
☐ Resident/Other

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Modified 12/22/25