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- Affix label here -  
Clinical Center/ID: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
First Name \_\_\_\_\_ M.I. \_\_\_\_\_  
Last Name \_\_\_\_\_

1. Date of scan: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ (M/D/Y)

2. Performed by: \_\_\_\_\_

3. Contact type:  
 <sub>1</sub> Phone     <sub>3</sub> Visit  
 <sub>2</sub> Mail      <sub>8</sub> Other

4. Visit type:

<sub>1</sub> Screening        # \_\_\_\_\_  
 <sub>2</sub> Semi-Annual        # \_\_\_\_\_  
 <sub>3</sub> Annual                # \_\_\_\_\_  
 <sub>4</sub> Non-Routine

**CHECKLIST**

5. "Have you had any fracture or replacement of the following?"

	No	Yes	→	"Which Side?"	
Femur?	_____	_____		_____ Left	_____ Right
Hip?	_____	_____		_____ Left	_____ Right

*(If hip replacement on both sides, do not do bone scan.)*

6. "Do you have any metal objects (such as staples or a pacemaker) in the area of the abdomen?"

\_\_\_\_\_ No      \_\_\_\_\_ Yes

7. "Have you had any of the following tests within the past ten days?"

- a) "Barium enema"                                \_\_\_\_\_ No    \_\_\_\_\_ Yes
- b) "Upper GI X-ray series"                    \_\_\_\_\_ No    \_\_\_\_\_ Yes
- c) "Lower GI X-ray series"                   \_\_\_\_\_ No    \_\_\_\_\_ Yes
- d) "Nuclear medicine scan"                   \_\_\_\_\_ No    \_\_\_\_\_ Yes
- e) "Other tests using contrast ('dye') or radioactive materials"    \_\_\_\_\_ No    \_\_\_\_\_ Yes

*(If yes to any, you may need to reschedule the bone density measurement; consult with CC physician.)*

**TESTING**

8. Bone Density Measurement completed for:

	No	Yes		Current Bone Scan Number		Comparison Bone Scan Number
8.1. Hip?	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	→	8.1.1. _____	8.1.2. _____	
				8.1.3. At screening: Baseline Femoral Neck BMD	_____	
8.2. Spine?	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	→	8.2.1. _____	8.2.2. _____	
8.3. Total Body?	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	→	8.3.1. _____	8.3.2. _____	

K \_\_\_\_\_ V \_\_\_\_\_