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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:

☐₁ Phone ☐₃ Visit

☐₂ Mail ☐₈ Other

4. Visit type:

☐₁ Screening # ____

☐₂ Semi-Annual # ____

☐₃ Annual # ____

☐₄ 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"/> ₀	<input type="checkbox"/> ₁	→	8.1.1. ____	8.1.2. ____	
				8.1.3. At screening: Baseline Femoral Neck BMD	____	
8.2. Spine?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	→	8.2.1. ____	8.2.2. ____	
8.3. Total Body?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	→	8.3.1. ____	8.3.2. ____	

K ____ V ____