700 Main Street, Suite 100
Alamosa, Colorado 81101
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Osteoporosis – Bone Density Screening Checklist

Please complete and send with requests for bone density tests.

Name: _____ID#: _____

This patient meets the following criteria (needs to meet only one of the four):

1) ☐ Postmenopausal female ≥ 65 years of age

2) ☐ Postmenopausal female, any age, with one of the following:

   a) ☐ Low or no trauma fracture DATE_____ SITE_____

   b) ☐ Weight < 127 lbs WT_____ HT _____

   c) ☐ Sister / mother with hip / vertebral fracture (please circle relationship and site)

   d) ☐ Previously documented osteoporosis or osteopenia (please provide documentation)

   e) ☐ Secondary cause of osteoporosis

      i) ☐ Hyperparathyroidism

      ii) ☐ Multiple myeloma

      iii) ☐ Vitamin D deficiency

      iv) ☐ Uncontrolled hyperthyroidism

      v) ☐ Chronic malabsorption

      vi) ☐ Other explain: _____

3) ☐ Male or pre-menopausal female with secondary cause of osteoporosis (use check list above to indicate cause)

4) ☐ Male or pre-menopausal female with no-trauma or minimal trauma fracture

NOTE: Bone mineral density screening is covered once every two years for members who meet one of these criteria.