DEXA (Bone Density Test) Referral

Office: HonorHealth Rheumatology & Infusion
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Patient Information

Name/First _____Middle_____Last_____ SSN: _____-____-_____
Date of Birth: _____/_____/____ Sex: M | F Patient street address: _____
City: _____ State: _____ ZIP: _____-_____
Primary Phone Number: (_____) _____-_____Mobile | Home | Work
Secondary Phone Number: (_____) _____-_____Mobile | Home | Work
Email address: _____

Insurance Information

Medical Insurance Company Name: _____
Member/Subscriber Identification #: _____ Group #: _____
Medical Insurance Company Address: _____
Relationship of the insurance subscriber to the patient: Self | Parent | Spouse | other: _____
Subscriber: Name/ First_____Middle_____Last_____

Referral Indication

☐ Osteoporosis ☐ Osteopenia

☐ Fragility fracture(s) ☐ Other: _____

DEXA Order

☐ Axial DEXA scan to include AP spine and bilateral total hip & femur neck -CPT code 77080

☐ One third non-dominant radial site-CPT code 77081

☐ Axial DEXA + One third non-dominant radial site - CPT code 77080+77081

Would you like our rheumatologist specializing in osteoporosis to see the patient for management if bone density is abnormal?

☐ Yes ☐ No

Referring Provider Information

Referring Provider Name: _____ Office Phone Number: _____

Referring Provider Signature: _____ Date: _____

Step 1: Fax this form, along with patient medical documentation (if available)
Step 2: Our Osteoporosis coordinator will contact the patient to schedule an appointment
Step 3: You will receive a confirmation of your patients' appointment status