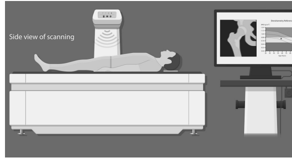
BONE DENSITY SCAN (DEXA): PATIENT INSTRUCTIONS

MUST READ

Step 1: Read

A Bone Density Scan (DEXA) gives your doctor insight on your bone make up so you and your doctor can help protect your bones.

The actual scan takes approx. this much time



Step 1:
Get Bone Density Scan*

You'll come to OSS and work with our licensed radiological technologist. You'll lay on a table and the machine will take images of the bones in your hip, spine, or forearm. The computer in the machine will then calculate a density score (called the T Score). This score will tell your provider the health of your bones.

Benefits

- **Low radiation.**
- Takes 2-dimensional image of **spine, hip** and/or **forearm.**

Step 2:
Follow Up with Provider

About a week later, you'll meet with your provider either virtually (telehealth) or in person. During this visit, you'll discuss next steps.

YOU **MUST CANCEL** the **bone density scan appointment** if you:

- Are you **pregnant** or **possibly pregnant?**
- Had a CT Scan or a Radioisotope **WITH barium** or **received an injection of contrast** or had a nuclear medicine test.

Step 2. Fill out Bone Density Safety / Consent form + Follow Checklist

Before Imaging Appointment (1 Day Before)

- Complete **Bone Density Safety / Consent**, (either get at ossburbank.com or at OSS office).
- Complete the **Medication Form**, if needed.
- **24 hours before appointment, stop taking any calcium supplements** (calcium pills)

Day of imaging:

- **What to wear?** Wear comfortable, loose fitting clothes to your exam. Avoid wearing metal (zipper, buckles, metal clasps). Remove piercings. Wearing eye contacts is okay. Please do not wear jewelry. Please understand that you may be asked to change into a gown provided by OSS, if required.
- **Arrive 15 minutes early to OSS** (3413 W. Pacific Ave, Suite 100, Burbank, CA 91505).
- Please **bring** your insurance card, photo ID, and payment (if and as discussed).

Bring the Bone Density Scan SAFETY / CONSENT form to your appointment.

OSS
ossburbank.com

Imaging
3413 W. Pacific Ave, Suite #100
Burbank, CA 91505
T (818) 841-3936 | F (818) 841-5974
ossburbank.com

Bone Density Scan Safety / Consent Form

Please complete this required form.

Patient Name Last First M.I. ______________________

Today's Date MM/DD/YYYY ______________________

Sex ☐ Female ☐ Male

Height in ______ Weight lbs ______ Date of Birth MM/DD/YYYY ______________ Age ______

Race / Ethnicity ☐ Asian ☐ Hispanic ☐ Caucasian ☐ African American ☐ Other

Name of the provider who ordered the bone scan? ______________________

After the bone scan, name of provider you were told to see? ______________________

1. To **ensure your safety,** please **check** the check box **if YES.**

In the last 7 days, have you had a: ☐ CT Scan with Contrast ☐ Nuclear Medicine Test ☐ X-Ray with Barium (used for your gastrointestinal tract)

☐ Is there a chance you can be pregnant? ☐ Have you taken calcium supplments in the last 24 hours?

	Yes	No
2. Are you **CURRENTLY taking any medication** (e.g., steroid)? and **what medications** (include strength / dose)?	☐	☐

If yes, what medications (please include strength / dose)? ____

	Yes	No
3. Have you ever **broken your hip** or **spine?**	☐	☐
4. In your adulthood, have you ever **broken a bone that was not** from a sudden, high impact trauma (like a car accident)?	☐	☐
5. Have you **ever had surgery** on your **spine, hip**, or **wrist**?	☐	☐
6. Are you experiencing a **loss of height**?	☐	☐

*What was your **maximum height** (in inches?)* ______________________

7. Have you ever been **DIAGNOSED** with any of these **CHRONIC** diseases?

	Yes	No
Rheumatoid arthritis	☐	☐
Secondary osteoporosis	☐	☐
Anorexia or Bulimia	☐	☐
Asthma or Emphysema	☐	☐
Issues with your thyroid *hyperthyroidism*	☐	☐
Any seizure disorders	☐	☐
Cancer	☐	☐
Inflammatory bowel disease	☐	☐
End stage renal disease	☐	☐

8. Are any of these activities part of your **lifestyle**?

	Yes	No
Smoking / tobacco use	☐	☐
Drink three (3) or **more alcoholic drinks** per day	☐	☐
Consume dairy routinely (e.g., milk, yogurt, cheese)	☐	☐
Drink caffeinated beverages	☐	☐
Lift weights regularly	☐	☐

9. **If female,** please answer:

At what age did you **start your period** (menstration)? ________

How many **full term pregnancies** have you had? ________

Have you ever had a **hysterectomy** (removal of uterus)? ________

	Yes	No
Are you **still having periods**?	☐	☐
Have you ever **missed your period** for more than **6 months in a row** (not because you were pregnant or in menopause)?	☐	☐

At what **age** did you have **menopause**? ________

	Yes	No
10. Your **Family History.** Have either of your **parents** ever had a **hip fracture?**	☐	☐

____
Name of Patient *Day, date, time*

____
Signature of Patient *Day, date, time*

____
Name & Signature of OSS Member Witness *Day, date, time*

Internal Use Only. ☐ Safety Check ☐ Medication Check

Disclaimer: Orthopaedic Surgery Specialists is the registered business official name of OSS.

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Bone Density Scan Safety / Consent Form
SUPPLEMENTAL: Medication List

Please complete this required form.

Patient Name Last First M.I. ______________________

Today's Date MM/DD/YYYY ______________________

Sex
☐ Female ☐ Male

Date of Birth MM/DD/YYYY ______________________

Age ________

Name of Medication	Strength (Dose)	Frequency

____
Name of Patient *Day, date, time*

____
Signature of Patient *Day, date, time*

____
Name & Signature of OSS Member Witness *Day, date, time*

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