

GREAT LAKES CENTER OF RHEUMATOLOGY WEST OSTEOPOROSIS CLINIC

Formerly Beals Institute

Fax completed form to (517) 321-7059

Phone (517) 886-5468

Date: _____ Referring Physician: _____

Phone: _____ Fax: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Home Phone: _____ Alt Phone: _____

Primary Insurance: _____

- | | |
|---|---|
| <input type="checkbox"/> M81.0 Age-related Osteoporosis w/o current fracture | <input type="checkbox"/> E89.40 Post procedural ovarian failure |
| <input type="checkbox"/> M80.0 Age-related osteoporosis with current fracture | <input type="checkbox"/> N95.1 Symptoms associated with menopause |
| <input type="checkbox"/> M80.80___ Other Osteoporosis | <input type="checkbox"/> E28.319 Asymptomatic premature menopause |
| <input type="checkbox"/> M85.80 Osteopenia with high risk of fracture | <input type="checkbox"/> Z78.0 Asymptomatic postmenopausal |
| <input type="checkbox"/> Z79.899 Other long term current drug therapy | <input type="checkbox"/> E03.9 Hypothyroidism |
| <input type="checkbox"/> Z92.241 Personal history of steroid therapy | <input type="checkbox"/> R29.809 Loss of Height |

SERVICES REQUESTED:

- Medical Management of Osteoporosis
- Bone Density Test
- Bone Density Test with follow-up visit for Osteoporosis counseling and treatment
- Fracture Liaison services

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Great Lakes Center of Rheumatology West will contact the patient and arrange an appointment time and date. We will send appointment verification to the referring doctor.

Appointment Date: _____

Appointment Time: _____

This information is confidential and is entrusted to the person whose name appears on this form. Unauthorized use of this information is a breach of confidentiality, and the Great Lakes Center of Rheumatology West will report all such violations to the appropriate authorities and will assist in the prosecution of all violators. If you receive this fax in error, please destroy this material and call us so we can correct the error.