

Name: _____
 M.R.N.: _____
 D.O.B.: _____
 Phone Number _____

- DEXA BONE DENSITOMETRY
DEXA - ABSOLUTE CONTRAINDICATIONS: PREGNANCY, NUCLEAR MEDICINE/CONTRAST STUDY WITHIN PAST 7 DAYS.
- DEXA BODY COMPOSITION ANALYSIS
DEXA - ABSOLUTE CONTRAINDICATIONS: PREGNANCY, NUCLEAR MEDICINE/CONTRAST STUDY WITHIN PAST 7 DAYS.
- DIABETIC RETINAL IMAGING (FUNDUS PHOTOGRAPHY)
- CONTINUOUS GLUCOSE MONITORING SYSTEM
- CAROTID INTIMAL-MEDIAL THICKNESS ANALYSIS
- 24 - HOUR AMBULATORY BLOOD PRESSURE MONITORING
- THYROID ULTRASOUND
- THYROID ULTRASOUND W/ BIOPSY
(Please Note: Endocrinology consultation required)
- NERVE CONDUCTION MEASUREMENT
 - Median / Ulnar Left Right BOTH
 - Peroneal / Tibial Left Right BOTH
 - Sural Nerve Left Right BOTH

Rx Physician Test Order

This form can be downloaded & completed online @ <http://www.endocrinology.med.ucla.edu/forms.htm>.
 The completed form can then be e-mailed as an attachment to gdcdiagnostic@mednet.ucla.edu or printed and faxed to the number below.

Patient Name: _____
(If no label attached)

MR# _____
(If no label attached) 00-00-000

DOB: _____
(if no label attached)

Tel# _____
(if no label attached)

Clinical Indications for study:
(Required) →

Executive Health Patient ? ←

Clinical History and Medications:

Ambulatory Wheelchair

Please check if patient is taking any of the following:	<input type="checkbox"/> Estrogen	<input type="checkbox"/> Evista	<input type="checkbox"/> Forteo	<input type="checkbox"/> Diuretics
	<input type="checkbox"/> Fosamax	<input type="checkbox"/> Actonel	<input type="checkbox"/> Boniva	<input type="checkbox"/> Anti Coagulants
Steroids: <input type="radio"/> Oral <input type="radio"/> Inhaled	<input type="checkbox"/> Miacalcin	<input type="checkbox"/> Thyroxine	<input type="checkbox"/> BP Medications	

Referring Physician's Signature: _____

Referring Physician's Name: _____

Pager# _____

Referring Physician's Tel# _____

Fax# _____

Send additional copies of report to: