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DR. JEANNE NICHOLS, PhD
PROGRAM DIRECTOR
DEPARTMENT OF FAMILY MEDICINE AND PUBLIC HEALTH
UNIVERSITY OF CALIFORNIA, SAN DIEGO

9500 GILMAN DRIVE MC0811
LA JOLLA, CA 92093-0811
PHONE: (858) 822-7624
FAX: (858) 534-9404

Date: _____

To: [Physician] _____

Re: DXA Scan Approval Request

Patient name:_____

DOB:_____

Date of scan visit:_____

Dear Doctor,

We are requesting your medical approval for this patient to proceed with a Dual-energy X-ray Absorptiometry (DXA scan). One of your patients is interested in receiving a DXA scan as volunteer at our School of Bone Densitometry at the University of California, San Diego, where we train DXA technicians for CA state certification. With your approval, your patient will be scanned by our DXA trainees under close supervision by one of our Certified DXA Technicians. Volunteers will receive a single scan at each of the following sites: hip, lumbar spine and forearm, and a whole body scan for body composition assessment. The total radiation exposure to your patient will be 7-10 μSv, which is approximately equivalent to one day of outdoor exposure in southern California. The only restriction to scanning is pregnancy, for which we will screen by self-report, or offer an OTC test if requested. There is no charge to your patient for participating, nor will we bill their insurance company.

Additional COVID-19 risk: Volunteers will be in an enclosed room with 1-2 trainees and 1 instructor for at least 20 minutes. All individuals will be required to wear PPE, but this prolonged exposure may pose an increased risk for certain individuals with underlying medical conditions. If your patient is over 65 and/or has any of the health conditions considered “higher risk” by the CDC [Cancer, Chronic kidney disease; COPD (chronic obstructive pulmonary disease); Immunocompromised state (weakened immune system) from solid organ transplant; Obesity (body mass index [BMI] of 30 or higher); Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies; Sickle cell disease; Type 2 diabetes mellitus] we also ask that you specifically attest their condition is well controlled if you approve them to participate.

If you agree to your patient’s participation, please sign below and fax this form back to our DXA School Administrator, Ms. Lauren Claravall at (858) 534-9404 or email to ucsdboneschool@gmail.com. Do not hesitate to call us at (858) 822-7624 with any questions.

Sincerely,

Jeanne Nichols, PhD
Program Director
UCSD Bone Densitometry School

Your signature below indicates your approval of your patient’s participation in DXA scanning as noted above.

☐ My patient, _____, is **under 65** years old and **does not have** any of the above listed medical conditions. I **APPROVE** them to participate in the DXA scan with no restrictions.

--OR--

☐ My patient, _____, is **over 65** years old and/or **has one or more** of the above listed medical conditions that is well controlled. I **APPROVE** them to participate in the DXA scan with no restrictions.

--OR--

☐ I **DO NOT APPROVE** my patient, _____, to participate in the DXA scans at this time.

_____ _____ _____

Physician’s Name (*Please print)* Physician’s Signature Date

☐ I would like a copy of my patient’s final DXA report faxed or emailed to: _____