

**BONE DENSITY SCAN REFERRAL**  
**ATTN: DR. GARY M. CHAN, M.D.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CPT CODE:

77080 DEXA AXIAL (SPINE, HIP)

77081 DEXA PERIPHERAL: (FOREARM & OTHER SITES)

76977 QUANTITATIVE ULTRASOUND (PERIPHERAL)

76499 DEXA TOTAL BODY

ICD-9 Code: \_\_\_\_\_

Appt. Date/Time: \_\_\_\_\_

Billing Information: \_\_\_\_\_

Primary Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

DOB: \_\_\_\_\_ ID#: \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Name & Information: \_\_\_\_\_  
\_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Authorization Number (If Needed): \_\_\_\_\_

Ordering Physician Signature: \_\_\_\_\_

Contact # 801-581-3083 (*Gurmail Gill*)

Fax # 801-585-1110 or 801-585-7395