



Name: _____ Date: _____ Age: _____ Sex: _____

DOB: _____ Height: _____ Weight: _____

Please schedule the above client for a total body scan, via iDexa, to measure body composition.

Physician's Name (Print) _____

Physician's Address _____

Schedule for Dexa scan: yes no

Physician's Signature: _____

Remit to:

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