Talbot Family Health Organization
Dr. Kimberly Thompson MD., CCFP
Billing #031627 CPSO# 98021
1-294 Talbot Street, St.Thomas, On N5P 4E3
Phone: 226-210-3773 Ext 100 Fax: 519-914-0122

Nov 1, 2025

Dr. Lisa-Anne Fraser
The London Centre for Endocrinology and Bone Health
410-140 Oxford Street
London, ON
N6A 5R9

Dear Dr. Lisa-Anne Fraser:

Re: Sandra (Sandra) Goodman Feb 17, 1967 Age: 58 yr HN: 1763 145 750 WN

45 Edgewell Cres, St. Thomas, ON, N5P 4K9
Home: 519-207-1908
Cell:
Health Card: ON 1763 145 750 WN
email: sg2441@gmail.com

Thank you for seeing Sandra Goodman, a 58 year old female regarding severe osteoporosis with 2 recent vertebral compression fractures. She has only intermittent drug coverage and has been inconsistent with her ability to obtain her Prolia. I wonder if she would qualify for more intensive therapy. She is also a T2DM with variable BG control, also due to inconsistent drug overage.

I have attached pertinent labs and/or investigations. Please do not hesitate to contact me if further information is required.

Medical Problems
COPD/Asthma Overlap
T2DM with nephropathy - poor med compliance
DYSLPD
Left S1 compression and DDD + sciatica, foot drop - improving
Fatty Liver
Ant vaginal prolapse - Pessary - Dr. Reddy
Left Sacroiliac Insufficiency Fracture on CT July 27, 2022. Now on Prolia.
T7+T8 vertebral wedge # 2025
Osteoporosis

History of Past Health

Re: Sandra (Sandra) Goodman Feb 17, 1967 Age: 58 yr HN: 1763 145 750
WN

Cholecystectomy
Wisdom teeth extraction
Nephrolithiasis - recurrent episodes
Cystoscopy for stone retrieval ?2013
PEs age 23 - unclear etiology, had varicella at time
Gestational Diabetes x 2

Current Medication
calcium 1200 mg daily for 100 days
vitamin D : cholecalciferol (D3) 2000 units daily for 100 days
Patanol 0.1 % 2 drops 2 times daily, PRN
Naprosyn 1 tablet 2 times daily for 100 days
Prolia 1 syringe every 6 months
Ventolin HFA 100 mcg/actuation 1-2 inhalations every 4 hours, PRN
Spiriva 18 mcg 1 capsule 1 time daily for 100 days
gabapentin 3 capsules 3 times daily for 100 days
rosuvastatin 20 mg 1 tablet 1 time daily for 100 days note increased dose
Synjardy 5-1,000 mg 5-1 ,000 mg 1 tablet 2 times daily for 100 days
Synthroid 1 tablet 1 time daily for 100 days
Breztri Aerosphere 160-7.2-5 mcg/actuation 2 inhalations 2 times daily for 100 days

Allergies
? Penicillins-> Rash
? Sulfa (Sulfonamides)-> Diarrhea
? Cephalosporins-> unknown reaction

Social History
current smoker - 10-15 cigarettes/day
rare alcohol consumption
sedentary lifestyle
NO dentist or opto

Vitals
Weight: 57.3
Height: 161.5
BMI: 22.0

Thank you for contacting this patient and our office with their appointment details. We would also appreciate if you could advise us if you are unable to accept this referral or your approximate wait time so we can plan care in the interm.

Re: Sandra (Sandra) Goodman Feb 17, 1967 Age: 58 yr HN: 1763 145 750
WN

Please note: our office back number is 226-210-3773 ext 100

Yours truly,

Dr Kimberly Thompson

Jun 28, 2022 HRM Bone Scan, Diagnostic Radiology, Nuclear MedicinePAZ

Diagnostic Imaging Report
Nuclear Medicine, 362608, NM bone scan-total body
Observation Date: 28/06/2022, 08:14
Author physician: Barfett
St. Thomas Elgin General Hospital
Patient: Sandra Ann Goodman
DOB: 1967-02-17

INDICATION:

Sclerosis at T1.

COMPARISON:

June 13, 2022 CT scan

FINDINGS:
Dynamic blood flow images of the thorax are normal. The total body blood pool images are normal. Delayed skeletal phase total body images and SPECT demonstrate focal increased activity at the right lateral 6th rib in keeping with healing fracture. There is also focal increased activity at the xiphoid process of the sternum. Intense increased activity at the left medial iliac bone. There is no correlating lesion on the old CT of 2014.

IMPRESSION:

1) appearances are suspicious for an osteoblastic abnormality at the left sacroiliac region. Recommend CT pelvis correlation.

2) focal increased activity right lateral 6th rib in keeping with healing fracture. There is also likely healing fracture at the xiphoid process of the sternum, no definite CT correlate.

3) no suspicious activity at T1.

Date Dictated: 2022/06/28 14:01
Reporting Radiologist: Dr. Barfett, Joseph
Electronically Signed By: Barfett, Joseph
Date Signed: 2022/06/28 14:06
tr: Voice, Recorded
Ordering: Andrew Park

Aug 18, 2022 HRM Bone Densitometry MZ

Diagnostic Imaging Report
RAD, 38268-9, DXA Skeletal Sys Views for BMD
Observation Date: 18/08/2022, 01:32
Author physician: Yeung
PS Suite insert: Information available in attachments

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Elgin Imaging Services
119-230 First Avenue, St.Thomas, ON, N5R 4P5
Phone: 519 631 6437 Fax: 519 631 9991

Goodman, Sandra (F)
DOB: 17 Feb 1967 (55Y)
Health No: 1763145750 WN
Phone: (519) 207 1908
ID: 130700 Date: 18 Aug 2022

Dr. Mateusz Zajac
Eisi - Elmdale - 25 Elm St.
Ph: (226) 210 3773 Fx: (519) 914 0122

INDICATION: ☑ Baseline study

DEMOGRAPHICS:

Gender: Female
Height: 161.5 cm
Age: 55.5 years
Weight: 56.4 kg

HISTORY:

Significant Corticosteroid Use[1]: No
Bisphosphonates/Bone Strengthening Agents: No
History of Fragility Fracture After Age 40: No

BONE DENSITY VALUES:

REGION		BMD (g/cm^2)	T-SCORE
Lumbar Spine	(L1-L4)	0.845	-2.8
Femoral Neck	Left	0.805	-1.7
Total Hip	Left	0.759	-2.0

LIMITATIONS:

Lumbar Spine: None
Hip: None

DIAGNOSTIC CATEGORY[2]: ☑ Osteoporosis

10 YEAR FRACTURE RISK: ☑ Moderate (10-20% 10-year absolute fracture risk)

MANAGEMENT CONSIDERATIONS/THERAPY: With moderate 10-year absolute fracture risk, in addition to nutritional and lifestyle adjustments, the patient may benefit from pharmaceutical therapy if there are clinical risk factors predisposing to rapid bone loss or fractures.

FOLLOW-UP RECOMMENDATIONS:

Next OHIP eligible BMD: 1 year

[1] More than 7.5 mg Prednisone equivalent for three months in the previous year

[2] **BMD Diagnostic Criteria: 50 years and older:**

- T score greater than or equal to -1.0 = Normal
- T score between -1.0 and -2.5 = Low Bone Mass
- T score less than or equal to -2.5 = Osteoporosis

Finalized Date: 18 Aug 2022 Reading Physician: Dr. Eugene Yeung, M.D.,F.R.C.P (C)

Apr 22, 2025 HRM Chest X-Ray KT

Diagnostic Imaging Report
General Radiology, 361878, Chest PA/Lat
Observation Date: 22/04/2025, 17:38
Author physician: Mercado
St. Thomas Elgin General Hospital
Patient: Sandra Ann Goodman
DOB: 1967-02-17

Chest PA/Lat

HISTORY:
R cp nyd

COMPARISON:
October 20, 2024.

FINDINGS:
The lungs appear clear with no evidence for airspace consolidation or pulmonary edema identified. No pleural effusions or pneumothorax seen.

Cardiomediastinal silhouette within expected limits with heart size not enlarged. Trachea midline.

Moderate anterior wedge compression fracture of a midthoracic vertebral body and possibly the T7 vertebral body with approximately 50-60% loss of vertebral body height anteriorly, new compared to previous. Visualized bones appear osteopenic.

IMPRESSION:
No evidence for acute intrathoracic process identified.

Moderate anterior wedge compression fracture of a midthoracic vertebral body as described above which is new compared to chest x-ray from October, 2024. -
Date Dictated: 2025/04/22 17:54
Reporting Radiologist: Dr. Mercado, Ashley John
Electronically Signed By: Mercado, Ashley John
MD, FRCP(C)
Date Signed: 2025/04/22 17:57
tr: Voice, Recorded
Ordering: Bharbhoor Dhaliwal

Apr 22, 2025 HRM CT Scan Body KT

Diagnostic Imaging Report
CT, 18388774, CT Pulmonary Angio
Observation Date: 22/04/2025, 18:32
Author physician: Guo
St. Thomas Elgin General Hospital
Patient: Sandra Ann Goodman
DOB: 1967-02-17

ORIGINAL REPORT

CT CHEST WITH CONTRAST PE PROTOCOL

COMPARISON: Chest two views earlier on the same day. CT PE study on June 13, 2022

FINDINGS:

Adequate contrast opacification of the pulmonary vasculature. No evidence for acute pulmonary embolism. The main pulmonary artery is not dilated. No acute right heart strain.

Visually, the cardiac chambers are normal in size. No pericardial effusion or thickening. The thoracic aorta is normal in caliber.

The visualized thyroid gland and esophagus are unremarkable. Small hiatal hernia.

No thoracic lymphadenopathy.

Mild bronchial wall thickening with multifocal distal airway mucous plugging, most pronounced in the lingula and left lower lobe. There is hyperlucency involving the lung bases, suggestive of an element of air trapping. No focal consolidation. Mild basilar atelectasis.

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No pleural effusions or pleural thickening.

Limited views of the upper abdomen demonstrate no acute abnormality. Cholecystectomy.

Sclerotic lesion in T1 is unchanged. Interval development of chronic appearing compression fracture of T7

IMPRESSION:

No evidence for acute pulmonary embolism.

-

Date Dictated: 2025/04/22 19:01
Reporting Radiologist: Dr. Guo, Lancia
Electronically Signed By: Guo, Lancia
Date Signed: 2025/04/22 19:00
tr: RTM, System
Ordering: Bharbhoor Dhaliwal

May 23, 2025 LifeLabs Medical Laboratories Lab Data (Updated) KT

Accession Number 2025-HZ1430594
Collection Date May 23, 2025 10:35AM
Ordering Physician: Thompson, Kimberly
Primary Testing Location:6560 Kennedy Road Mississauga L5T 2X4 1(877)849-3637

HEMATOLOGY I			
WBC	10.9	4.0	- 11.0
RBC	4.53	4.00	- 5.10
Hb	143	120	- 160
Hct	0.421	0.350	- 0.450
MCV	93	80	- 100
MCH	31.6	27.5	- 33.0
MCHC	340	305	- 360
RDW	12.0	11.5	- 14.5
Platelets	348	150	- 400
HEMATOLOGY II			
Neutrophils #	7.6 (HI)	2.0	- 7.5
Lymphocytes #	2.4	1.0	- 3.5
Monocytes #	0.4	0.2	- 1.0
Eosinophils #	0.3	0.0	- 0.5
Basophils #	0.1	0.0	- 0.2
Immature Granulocytes #	0.0	0.0	- 0.1
Nucleated RBC's	0		
ROUTINE CHEMISTRY I			
Hb A1C	7.9 (HI)	<6.0	

Diabetes Canada 2018 Guidelines:

Screening and Diagnosis:
< 5.5 % Normal
5.5% - 5.9 % At risk
6.0% - 6.4 % Prediabetes
>OR= 6.5 % Diabetes Mellitus***

***Regarding diagnosis: in the absence of symptomatic hyperglycemia, if a single laboratory test result is in the diabetes range, a repeat confirmatory laboratory test (FPG, A1C, 2hPG in a 75 g OGTT) must be done on another day for diagnosis confirmation.

Monitoring: <OR= 7.0 %
Target in adults without comorbidities. Other targets may be more appropriate in children, elderly and patients with comorbidities.

Results may not accurately reflect mean blood glucose in patients with hemoglobin variants, disorders associated with abnormal erythrocyte turnover, severe renal and liver disorders.

ROUTINE CHEMISTY RENAL			
Cr	41 (LO)	50	- 100
eGFR	111	SEE BELOW	

Reference interval: ->60 mL/min/1.73m2

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eGFR is calculated using the CKD-EPI 2021 equation which does not use a race-based adjustment.

ROUTINE CHEMISTY RENAL

5-YEAR KFRE	NOT APPLICABLE	<5

Results rule out CKD stage 3-5 and albuminuria. The KidneyWise toolkit (kidneywise.ca) recommends remeasuring eGFR and urine ACR annually for people with diabetes mellitus and less frequently in others unless clinical circumstances dictate otherwise.

Microalbumin	16	

No reference interval has been established for this test.

Urine Creatinine Random	6.0	

No reference interval has been established for this test.

Microalbumin/Creatinine Ratio	2.7	<3.0

Diabetes Canada 2018 Guidelines reference cut-off is <2.0 mg/mmol.

ROUTINE CHEMISTRY

Na	141	135 - 145
K	4.5	3.5 - 5.2
ALT	22	<36

LIPID ASSESSMENT

Hours Fasting	3	
TG	1.53	

FASTING: <1.70 mmol/L
NON-FASTING: <2.00 mmol/L

CHOL	4.01	<5.20

Total cholesterol and HDL-C used for risk assessment and to calculate non HDL-C.

HDL	1.07 (LO)	>=1.30

HDL-C <1.30 mmol/L indicates risk for metabolic syndrome.

LDL	2.32	<3.50

LDL-C is calculated using the NIH equation.

For additional LDL-C and non-HDL-C thresholds based on risk stratification, refer to 2021 CCS Guidelines. Can J Cardiol. 2021;37(8):1129-1150.

NON-HDL	2.94	<4.30

Non HDL-Cholesterol is not affected by the fasting status of the patient.

CHOL/HDL	3.7	

Cholesterol/HDL-C is not included in the 2021 CCS guideline as a lipid initiation or treatment target but is recognized as an indicator of high CVD risk at Cholesterol/HDL-C ratio >6.0

SPECIAL CHEMISTRY II

TSH	1.07	0.32 - 4.00

Sep 2, 2025 **LifeLabs Medical Laboratories Lab Data** **KT**

Accession Number	2025-HZ2450060
Collection Date	Sep 2, 2025 8:06AM

Ordering Physician: Thompson, Kimberly
Primary Testing Location:6560 Kennedy Road Mississauga L5T 2X4 1(877)849-3637

ROUTINE CHEMISTRY I

Hb A1C	9.1 (HI)	<6.0

Diabetes Canada 2018 Guidelines:

Screening and Diagnosis:
< 5.5 % Normal
5.5% - 5.9 % At risk
6.0% - 6.4 % Prediabetes
>OR= 6.5 % Diabetes Mellitus***

***Regarding diagnosis: in the absence of symptomatic hyperglycemia, if a single laboratory test result is in the diabetes range, a repeat confirmatory laboratory test (FPG, A1C, 2hPG in a

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75 g OGTT) must be done on another day for diagnosis confirmation.

Monitoring: <OR= 7.0 %
Target in adults without comorbidities. Other targets may be more appropriate in children, elderly and patients with comorbidities.

Results may not accurately reflect mean blood glucose in patients with hemoglobin variants, disorders associated with abnormal erythrocyte turnover, severe renal and liver disorders.

ROUTINE CHEMISTY RENAL

Cr	44 (LO)	50 - 100
eGFR	109	SEE BELOW

Results rule out CKD stage 3-5. Assessment of urine ACR is required to definitively rule out or confirm CKD diagnosis. The KidneyWise toolkit (kidneywise.ca) recommends remeasuring eGFR and urine ACR annually for people with diabetes mellitus and less frequently in others unless clinical circumstances dictate otherwise.

Reference interval: =>60 mL/min/1.73m2

eGFR is calculated using the CKD-EPI 2021 equation which does not use a race-based adjustment.

LIPID ASSESSMENT

Hours Fasting	9	
TG	1.17	

FASTING: <1.70 mmol/L
NON-FASTING: <2.00 mmol/L

CHOL	3.33	<5.20

Total cholesterol and HDL-C used for risk assessment and to calculate non HDL-C.

HDL	1.37	>=1.30

HDL-C <1.30 mmol/L indicates risk for metabolic syndrome.

LDL	1.47	<3.50

LDL-C is calculated using the NIH equation.

For additional LDL-C and non-HDL-C thresholds based on risk stratification, refer to 2021 CCS Guidelines. Can J Cardiol. 2021;37(8):1129-1150.

NON-HDL	1.96	<4.20

Non HDL-Cholesterol is not affected by the fasting status of the patient.

CHOL/HDL	2.4	

Cholesterol/HDL-C is not included in the 2021 CCS guideline as a lipid initiation or treatment target but is recognized as an indicator of high CVD risk at Cholesterol/HDL-C ratio >6.0

ROUTINE CHEMISTRY

ALP	139 (HI)	35 - 120
Albumin	45	35 - 52

ROUTINE CHEMISTRY

Ca	2.39	2.15 - 2.60

SPECIAL CHEMISTRY II

Vitamin D (25 hydroxy)	95.6	75.0 - 250.0

Sep 17, 2025 HRM Misc. MRI Scan KT

Diagnostic Imaging Report
MRI, 363679, MR Spine Thoracic
Observation Date: 17/09/2025, 08:31
Author physician: Lynch
St. Thomas Elgin General Hospital
Patient: Sandra Ann Goodman
DOB: 1967-02-17

MRI THORACIC SPINE

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CLINICAL HISTORY:
ct shows T7 compression # has radicular pain wrapping around torso in dermatome, assess for nerve root compression for interventional procedures

TECHNIQUE:
Multiplanar multi sequence MR of the thoracic spine was performed without contrast.

COMPARISON:
CT pulmonary angiogram April 22, 2025 as well as MRI of the lumbar spine from 2018

FINDINGS:
Thoracic spine demonstrates a focal kyphosis at the T7/T8 level related to underlying compression fractures.

There is redemonstration of the known chronic compression fracture at T7, with slight progressive height loss since the April CT. Anteriorly, there is now greater than 66% height loss. There is no associated marrow edema within this vertebral body. There is some mild marrow edema within the inferior articular process is of T7 which could be reactive.

Additional new moderate anterior wedge compression fracture present involving T8 with moderate marrow edema. Height loss estimated at greater than 50% anteriorly.

There is no significant spinal canal stenosis as result, and no clear severe narrowing of the neural foramina at these levels, without any definitive neural impingement.

There are no other foci of suspicious marrow signal abnormality, with chronic sclerotic focus at T1 and scout images demonstrating a chronic hemangioma within L5.

The thoracic cord does not demonstrate any pathologic signal.

The visualized paravertebral soft tissues are unremarkable.

IMPRESSION:
Known chronic compression fracture at T7 has demonstrated some mild progressive height loss since the initial April CT. Since then, there has been development of a new moderate compression fracture T8 with persisting bone marrow edema consistent with an acute/subacute timeline. There is no significant spinal canal stenosis or clear neural impingement at these levels, with a developing kyphosis. -
Date Dictated: 2025/09/17 10:14
Reporting Radiologist: Dr. Lynch, Peter MD FRCPC
Electronically Signed By: Lynch, Peter MD FRCPC
Date Signed: 2025/09/17 10:24
tr: Voice, Recorded
Ordering: Kimberly Thompson

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