BAMF Health Theranostics Center - Molecular Imaging Clinic
109 Michigan Street NW, Suite #100 - Grand Rapids, MI 49503
Phone: (888) 987-5515 - Fax: (616) 282-2042
www.BAMFhealth.com

BAMF PET/CT Order Form

Revised: 2023_03_05

Date Imaging Needs Completed:_____ (Scans will be completed up to 10 days prior to this date)

PATIENT INFORMATION and HISTORY

☆ BAMF will obtain authorization for scan ☆

Name:_____ Date of birth:_____ ❒ Male ❒ Female

Primary phone:_____ Alternate phone:_____ Height:_____ Weight:_____

Iodinated contrast allergy? ❒ Yes ❒ No Pregnant or Breastfeeding? ❒ Yes ❒ No

Patient diabetic? ❒ Yes ❒ No - Medications taken: ❒ None (Diet Controlled) ❒ Oral Meds (Metformin ❒ Yes ❒ No) ❒ Insulin

Patient ambulatory? ❒ Yes ❒ No If no, how much assistance is needed for mobility and transfers?_____

Recent surgery/biopsy - Specific site/approx. date:_____

Chemotherapy - Type and date of last treatment:_____

Radiotherapy - Type and date of last treatment:_____

XRT - Type and date of last treatment:_____

Recent relevant imaging - Type(s), date(s) and location(s):_____

PET/CT EXAM REQUESTED* - Please check the box for requested exam

*Please note that the CT in PET/CT is for attenuation correction only.**

❒ Ga-68 PSMA Imaging - for suspected prostate cancer metastases or recurrence
❒ Ga-68 Dotatate - for neuroendocrine tumor
❒ F-18 FDG - for most cancers and neurologic diseases
❒ F-18 Amyloid Imaging - for Alzheimer's dementia
❒ F-18 NaF - bone metastases
❒ **F-18 FDG - brain, tumor-related
❒ **F-18 FDG - brain, dementia/seizure
❒ **F-18 Fluciclovine - for prostate cancer recurrence
❒ **F-18 Fluoroestradiol - ER(+) detection in recurrent or metastatic breast cancer
❒ **Other PET Imaging:_____

***Please call (888) 987-5515 for availability*

Diagnostic CT Available Upon Request

Is Diagnostic CT requested in addition?
❒ Yes ❒ No

** Additional Charges Do Apply **

Only for Diagnostic CT

❒ Neck ❒ w/contrast ❒ w/out contrast
❒ Chest ❒ w/contrast ❒ w/out contrast
❒ Abdomen ❒ w/contrast ❒ w/o contrast
❒ Pelvis ❒ w/contrast ❒ w/out contrast
❒ Brain ❒ w/contrast ❒ w/out contrast
❒ XRT Planning ❒ w/contrast ❒ w/o contrast
❒ Other _____

Contrast at discretion of radiologist if not specified.

Was CDSM consulted for appropriate use? ❒ Yes ❒ No CPT_____ M or Q Result Code_____ G Code_____

Diagnosis:_____ ICD-10:_____

Reason for study: ❒ Initial treatment strategy (diagnosis/initial staging) ❒ Subsequent treatment strategy (restaging/monitoring/recurrence)

Referring provider's printed name:_____ Provider's NPI:_____

Referring provider's signature:_____ Date:_____

Please Provide any Additional Comments:

REFERRING INFORMATION

Provider's Phone:_____ Provider's Email:_____ Fax to Send Report:_____

Name of Facility:_____ Facility Contact:_____ Facility Phone:_____

Fax additional copies of report to:_____ Fax Number:_____

CHECK LIST FOR REFERRING PHYSICIAN'S OFFICE

❒ Completed order form (this form) ❒ Copies of CT, MRI, Nuc Med and PET reports
❒ Relevant office notes and pathology reports ❒ Copies of all insurance cards ❒ Copy of last report for CT labs