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