BAMF Health Theranostics Center - Molecular Imaging Clinic
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www.BAMFhealth.com

BAMF PET/CT & PET/MRI Order Form

Revised: 2023_05_23

Date Imaging Needs to be 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 EXAM REQUESTED* - Please check the box for requested exam

Please indicate PET/CT or PET/MRI: ❒PET/CT ❒PET/MRI

- ❒ 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*

CT & MRI Interpretation Requested

** Additional Charges Do Apply **

CT	MRI	CT or MRI Interpretation:
❒	❒	❒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:_____

If desired exam is not listed above, please write it below or add 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