BAMF Health

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CT Imaging Order Form

Revision 01-18-2024

Date Imaging Needed: _____ ***Scans to be completed up to 10 days prior***

PATIENT INFORMATION

Patient Name:				DOB:	
Patient Height:		Patient Weight:			*(lbs)*
Gender: ☐ Male ☐ Female		Patient Phone #:			
Patient Ambulatory: ☐ Yes ☐ No		Assistance Needed:			

ORDER INFORMATION

STAT Read: ☐ Yes ☐ No		Insurance Authorization #:		ICD10 Code:	
If image(s) are desired to be transferred to a health system please indicate here					
Facility Name:		Facility Phone #:			

OPTIONAL INFORMATION

Recent Surgery / Biopsy (Site/Approximate Date):					
Has the patient had previous imaging studies on this area of the body? ☐ Yes ☐ No					
Facility Performed:					
Does the patient have a known contrast allergy: ☐Yes ☐No ☐Unknown					
Contrast Prep Given: ☐ Yes ☐ No					
Patient Diabetic: ☐ Yes ☐ No	Medication Taken: ☐ None (Diet) ☐ Insulin ☐ Oral Meds				

REFERRING PROVIDER INFORMATION

Ordering Provider Name:					
Provider NPI:		Phone:		Fax:	
Additional Copies of Report to:				Fax:	

SPECIFIC REASON FOR STUDY

Complaint / Signs and Symptoms:	
Rule Out:	

STUDY REQUESTED

☐ Abdomen	☐ Lower Extremity, Left	☐ w/Contrast
☐ Cervical Spine	☐ Lower Extremity, Right	☐ IV
☐ Thoracic Spine	☐ Upper Extremity, Left	☐ Oral
☐ Lumbar Spine	☐ Upper Extremity, Right	☐ w/o Contrast
☐ Thorax (Chest)	☐ CTA Abdomen & Pelvis	☐ w/ & w/o Contrast
☐ Head	☐ CTA Abdominal Aorta & Le Runoff	
☐ Temporal Bone	☐ CTA Abdomen	
☐ Orbit	☐ CTA Chest (PE Protocol)	
☐ Pelvis	☐ CTA Head	
☐ Maxillofacial	☐ CTA Lower Extremity Left	
☐ Sinuses	☐ CTA Lower Extremity Right	
☐ Soft Tissue Neck	☐ CTA Neck	
	☐ CTA Upper Extremity Left	
☐ Other: _____	☐ CTA Upper Extremity Right	

PROVIDER SIGNATURE: _____ **DATE:** _____