BAMF Health

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
bamfhealth.com

MR 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 ☐ Brain ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Sacrum/SI Joints ☐ Orbit ☐ Pelvis ☐ TMJ ☐ Whole Body (76498)	☐ Lower Extremity, Joint (Hip, Knee, Ankle) ☐Left ☐Right ☐ Lower Extremity, Not Joint (Thigh, Lower Leg, Foot) ☐Left ☐Right ☐ Upper Extremity, Joint (Shoulder, Elbow, Wrist) ☐Left ☐Right ☐ Upper Extremity, Not Joint (Humerus, Forearm, Hand) ☐Left ☐ Right ☐ MRA Chest ☐ MRA Lower Extremity ☐ MRA Abdomen ☐ MRA Head ☐Other: _____	☐ w/Contrast ☐ w/o Contrast ☐ w/ & w/o Contrast

MRI PRESCREENING

Pacemaker	☐ Yes ☐ No	Metal Injury in Eyes	☐ Yes ☐ No
Aneurysm Clip	☐ Yes ☐ No	Prior Surgery to area being scanned	☐ Yes ☐ No
Stimulator	☐ Yes ☐ No	Pregnant / Breastfeeding	☐ Yes ☐ No
Implanted Medication Pump	☐ Yes ☐ No		

PROVIDER SIGNATURE: _____ **DATE:** _____