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

PET 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:			
☐ Histologically Proven ☐ Suspected		☐ Initial Scan	☐ Subsequent Scan
Rule Out:			

STUDY REQUESTED	**DIAGNOSTIC CT SCAN(S) REQUEST**	
☐ Total Body	(if applicable) Reason for Diagnostic CT:	
☐ Brain Only		
☐ Check here to have a diagnostic CT performed	☐ Chest ☐ Abdomen ☐ Pelvis ☐ Soft Tissue Neck	☐ w/ Contrast ☐ IV Contrast ☐ Oral Contrast ☐ w/o Contrast
☐ Other: _____		

RADIOTRACER	
☐ PSMA ☐ FDG ☐ DOTATATE ☐ BRAIN – AMYLOID (CPT Codes 78814 & Q9983)	
☐ OTHER:	

PROVIDER SIGNATURE: _____ **DATE:** _____