BAMF Health

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

STUDY REQUESTED

- ☐ Limited
- ☐ Skull Base to Mid-Thigh
- ☐ Whole Body
- ☐ Brain Only
- ☐ No diagnostic MR performed
- ☐ Other: _____

DIAGNOSTIC MR SCAN(S) REQUEST

(if applicable) Reason for Diagnostic MR:

- ☐ Brain
- ☐ Abdomen
- ☐ Pelvis
- ☐ Spine: _____

- ☐ w/ Contrast
- ☐ w/o Contrast
- ☐ w/o & w/ Contrast

RADIOTRACER

☐ PSMA ☐ FDG ☐ DOTATATE ☐ BRAIN - AMYLOID (CPT CODE 78811 & Q9983)

☐ OTHER:

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:** _____