BAMF Health Theranostics Center • Molecular Imaging Clinic
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CT Imaging Order Form

Revision 08-28-2025

Preferred Imaging Date: _____ ***Whenever possible, imaging to be completed within +/- 10 days***

***If Research** Study Name: _____ Subject ID: _____ Study Time Point: _____

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:	
Billing:	☐ Research ☐ Patient Insurance:				
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
LDCT Lung Cancer Screening:	☐ CTA Abdominal Aorta & Le Runoff	
☐ LDCT Initial	☐ CTA Abdomen	
☐ LDCT Subsequent	☐ CTA Chest (PE Protocol)	
☐ Head	☐ CTA Head	
☐ Temporal Bone	☐ CTA Lower Extremity Left	
☐ Orbit	☐ CTA Lower Extremity Right	
☐ Pelvis	☐ CTA Neck	
☐ Maxillofacial	☐ CTA Upper Extremity Left	
☐ Sinuses	☐ CTA Upper Extremity Right	
☐ Soft Tissue Neck		
☐ Other: _____		

Please provide any additional comments: _____

PROVIDER SIGNATURE: _____ **DATE:** _____

Order valid for 1 year after signature.