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 08-19-2025

Preferred Imaging Date: _____ **Whenever possible, imaging to be completed +/- 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 claustrophobic? ☐ Yes ☐ No ☐ Unknown				
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		

Please Provide any additional Comments:

PROVIDER SIGNATURE: _____ **DATE:** _____

Order valid for 1 year after signature.