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 08-19-2025

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

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

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

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

Please Provide any additional Comments:

PROVIDER SIGNATURE: _____ **DATE:** _____

Order valid for 1 year after signature.