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PET MR Imaging Order Form

Revision 03-12-2026

Date Imaging Needed: _____ ***Scans to be completed up to 10 days prior***

***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:			
☐ 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:
- ☐ Whole Body

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

RADIOTRACER

☐ PSMA ☐ FDG ☐ DOTATATE ☐ BRAIN - AMYLOID (CPT CODE 78811) ☐ 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	Electronic Ring	☐ Yes ☐ No

PROVIDER SIGNATURE: _____ **DATE:** _____