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 05-28-2024

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

☐ Total Body

☐ Brain Only

☐ Check here to have a diagnostic CT performed

☐ Other: _____

DIAGNOSTIC CT SCAN(S) REQUEST

(if applicable) Reason for Diagnostic CT:

☐ Chest	☐ w/ Contrast
☐ Abdomen	☐ IV Contrast
☐ Pelvis	☐ Oral Contrast
☐ Soft Tissue Neck	☐ w/o Contrast

RADIOTRACER

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

☐ OTHER:

Please Provide any additional Comments:

PROVIDER SIGNATURE: _____ **DATE:** _____