

FIRST	MIDDLE	LAST
DOB (required): / /		
Medical Record Number (if available): _____		
or Current Lucile Packard Children's Hospital Stanford Label		



- Authorization services • Saturday/Sunday & evening appointments • 3T MRI - High Speed CT - Pediatric sub-specialty expertise
- Complimentary valet parking • Music, movies, exam preparation to optimize patient's visit • Compassionate staff experienced in pediatric patients

Orders • Radiology Requisition **Scheduling (650) 497-8376 Fax (650) 724-2663**

INSURANCE Provider: _____ **Policy#:** _____ **Phone#:** _____
 (Insurance card (front & back) must be faxed if patient is not a current Lucile Packard Children's Hospital Stanford Patient)

SCAN: Routine Time sensitive: requirement _____ STAT: reason _____

Will exam need to be coordinated with other tests/appt? No Yes if yes, please specify _____

Special Needs: Translator, Language: _____ Other: _____

PARENT/Legal Guardian's Name: _____ **Specify relationship to patient (Mother, Father, etc):** _____

Best time to contact Parent/Legal Guardian: _____ **Phone#:** _____ **Cell#:** _____

Check one: Call Family to schedule Call Office to schedule (name/phone): _____

(min 3 & max 7 characters) Letter Number Letter or Number

DIAGNOSIS (ICD-10 Required): | | . | | | | | | **Symptoms:** _____

Underlying/Provisional Diagnosis: _____ **Clinical concern:** _____

Report Results: Routine Stat

<p>MRI*</p> <p><input type="checkbox"/> Contrast <input type="checkbox"/> W/O Contrast <input type="checkbox"/> With 3D Reconstruction</p> <p><input type="checkbox"/> Brain _____</p> <p><input type="checkbox"/> Brain w/MRA _____</p> <p><input type="checkbox"/> Abdomen _____</p> <p><input type="checkbox"/> Abdomen & Pelvis _____</p> <p><input type="checkbox"/> Abdomen & Pelvis w/MRA _____</p> <p><input type="checkbox"/> Other: _____ <input type="checkbox"/> R <input type="checkbox"/> L</p>	<p>ULTRASOUND</p> <p><input type="checkbox"/> South Bay <input type="checkbox"/> LPCH</p> <p><input type="checkbox"/> W/Doppler if necessary</p> <p><input type="checkbox"/> Abdomen</p> <p><input type="checkbox"/> Abdomen Limited Single organ _____</p> <p><input type="checkbox"/> Kidney and Bladder</p> <p><input type="checkbox"/> Kidney Transplant</p> <p><input type="checkbox"/> Pelvis</p> <p><input type="checkbox"/> Testicular</p> <p><input type="checkbox"/> Testicular With Doppler</p> <p><input type="checkbox"/> Extremity <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> Upper: _____</p> <p><input type="checkbox"/> Lower: _____</p> <p><input type="checkbox"/> Vascular <input type="checkbox"/> Non Vascular</p> <p><input type="checkbox"/> Other: _____</p>	<p>*Does patient have the following: (Required for MR/CT/Fluoroscopy)</p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Adverse Sedation Event</p> <p><input type="checkbox"/> <input type="checkbox"/> Adverse Anesthesia Event</p> <p><input type="checkbox"/> <input type="checkbox"/> CNS Abnormalities</p> <p><input type="checkbox"/> <input type="checkbox"/> Apnea/Snoring</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Airway Issue</p> <p><input type="checkbox"/> <input type="checkbox"/> Lung Disease/Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Development Delay</p> <p><input type="checkbox"/> <input type="checkbox"/> History of Renal Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> History of Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Sickle Cell</p> <p><input type="checkbox"/> <input type="checkbox"/> Cardiac Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Previous CT</p> <p><input type="checkbox"/> <input type="checkbox"/> Previous MRI</p> <p><input type="checkbox"/> <input type="checkbox"/> Previous Contrast Reaction</p>
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<p>CT* <input type="checkbox"/> Contrast <input type="checkbox"/> W/O Contrast</p> <p><input type="checkbox"/> With 3D Reconstruction</p> <p><input type="checkbox"/> Brain _____</p> <p><input type="checkbox"/> Facial Bones _____</p> <p><input type="checkbox"/> Sinus _____</p> <p><input type="checkbox"/> Chest _____</p> <p><input type="checkbox"/> Chest, Abd & Pelvis _____</p> <p><input type="checkbox"/> Other: _____ <input type="checkbox"/> R <input type="checkbox"/> L</p>	<p>X-RAY/FLUOROSCOPY*</p> <p><input type="checkbox"/> Chest PA/AP</p> <p><input type="checkbox"/> Chest 2V</p> <p><input type="checkbox"/> Extremity/Joint _____ <input type="checkbox"/> R <input type="checkbox"/> L</p> <p><input type="checkbox"/> Abdomen _____</p> <p><input type="checkbox"/> Pelvis _____</p> <p><input type="checkbox"/> Scoliosis _____</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Scoliosis (EOS/Emeryville only)</p>	<p><input type="checkbox"/> Cervical Spine _____</p> <p><input type="checkbox"/> Thoracic Spine _____</p> <p><input type="checkbox"/> Lumbar Spine _____</p> <p><input type="checkbox"/> VCUG</p> <p><input type="checkbox"/> UGI</p> <p><input type="checkbox"/> UGI with SBFT</p> <p><input type="checkbox"/> Modified Barium Swallow</p> <p><input type="checkbox"/> BE</p>	<p>If required, do you authorize an anesthesia consult? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, provide History and Physical with order/request.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>If female patient, has she started her period? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Certain imaging exams require a pregnancy test</p> </div>
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Practice/Clinic: _____ Phone#: _____ Fax#: _____ Pager#: _____

Primary Care Physician (Print Name) _____

DATE	TIME	Ordering Provider Signature:
		Print Name: _____ Credentials: _____ Pager Number if applicable: _____
DATE	TIME	Packard Provider Signature:
		Print Name: _____ Credentials: _____ Pager Number if applicable: _____

Directions to the Hospital

From US Highway 101 North or South

- Take the Embarcadero Road Exit West.
- Cross El Camino Real (becomes Galvez St).
- Turn right at Arboretum Rd, cross Palm Dr.
- Turn left on Quarry Rd.
- Turn right on Welch Rd.
- Parking will be on your left or right.

From Highway 280

- Take the Sand Hill Road Exit East.
- Turn right on Pasteur Dr.
- Turn left onto Welch Rd.
- Parking will be on your left or right.

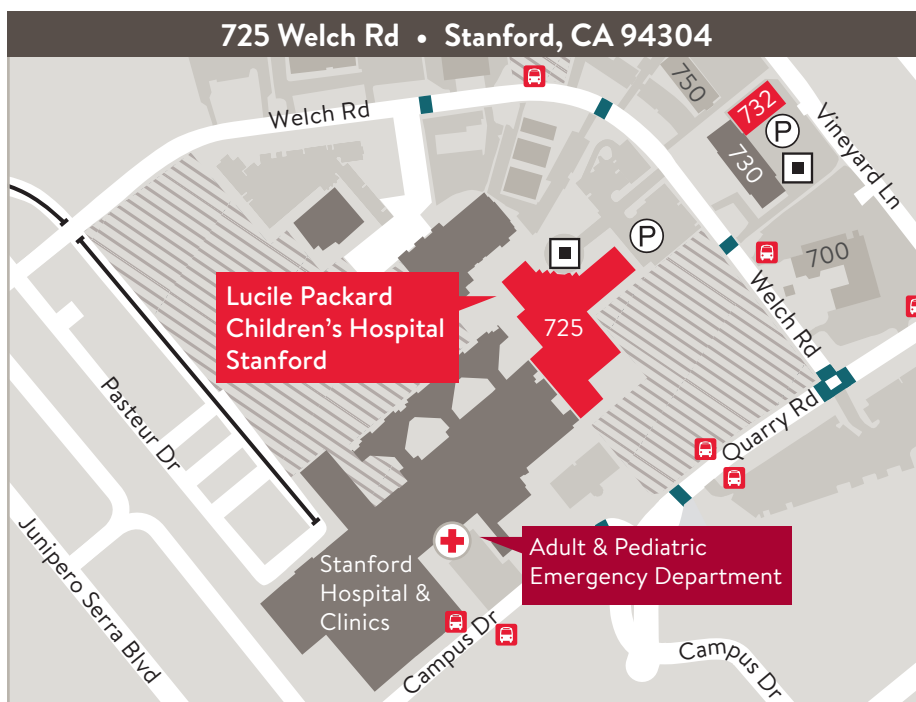
Where do I go?

Anesthesia Patients

Please go directly to the Ford Family Center located on the Ground Floor.

All Other Patients

Please go directly to Admitting (immediate right once you enter the hospital) and then proceed to 1st floor Radiology (next to the train station).



Through 2017, road closures/changes to Welch Road and Quarry Road will affect all traffic going to Lucile Packard Children's Hospital Stanford and our Palo Alto outpatient clinics. Please allow for 15 min of extra travel time. Visit stanfordchildrens.org to view revised maps and driving directions for each location.

Exam Preparation and Arrival Instructions

When is our Scan?

The scheduling department will be contacting you to schedule this appointment within 24 hours of submitting this form. The scheduling process for your child's exam requires several important prescreening steps.

Where do I park?

From Welch Road, turn into the Hospital Entrance. Complimentary Valet Parking is available from 6am–6pm (Monday–Friday) as well as Complimentary Self-Parking.

What time should we arrive for our Scan?

We customize the pre-scan preparation process for every child! We will provide you with an **Arrival Time** on your appointment date. Please plan accordingly, failure to arrive at your assigned time may result in long delays or your examination being rescheduled to another day.

Where do we go for an MR or CT exam?

- Are you an **Anesthesia** patient?—Proceed directly to the Ford Family Center (on the ground floor).
- All **Non-Anesthesia** patients can proceed directly to **Admitting** (immediate right once you enter the hospital), you then will be directed to 1st floor Radiology (next to the train station).
- If your child is not a current hospital patient, please bring a list of **all medications** your child takes, and all previous procedures (surgeries, implants, etc.).

Where do we go for our Ultrasound, X-Ray, Fluoroscopy exam or EOS in Emeryville?

- Proceed directly to **Admitting** (immediate right once you enter the hospital), you then will be directed to 1st floor Radiology (next to the train station).

- We offer scoliosis and leg length imaging at our Stanford Children's Specialty clinic in Emeryville using the EOS imaging system. 6121 Hollis Avenue Emeryville, CA.

Anesthesia Patients Special instructions

The parent/legal guardian will be contacted by a Nurse 1–2 days prior to your scan to obtain further patient history and review specific patient preparation anesthesia instructions. If for some reason this has not occurred, please call Scheduling at (650) 497-8376, 1–2 days before your visit.

Patient must provide 2 forms of ID (Name/Date of Birth) prior to exam at registration, and Parent/Guardian must provide picture ID.

Pregnancy Policy

Female patients who have started having menstrual periods may be required to complete a pregnancy test.