PATIENT NAME:

MRN:

DOB:

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

DEPARTMENT OF RADIOLOGY • IMAGE LIBRARY
IMAGE UPLOAD • REVIEW REQUEST FORM

• IMAGE LIBRARY LOCATIONS **• PHONE: (650) 723-6717** **• FAX: (650) 723-3995**

❑ MAIN HOSPITAL – 300 Pasteur Drive, 1ST FLR (H1328)
❑ STANFORD MEDICINE IMAGING CENTER – 451 Sherman Avenue, Palo Alto
❑ STANFORD MEDICINE OUTPATIENT CENTER – 450 Broadway, Redwood City

PHYSICIAN INFORMATION

Referring Location: _____ (Clinic) or _____ (Office Phone #) and _____ (Fax #)

Ordering Physician: _____ (Print Name) _____ (Signature) _____ (Date) _____ (Time) _____ (Pager)

Attending/PCP: _____ (Print Name) _____ (Signature) _____ (Date) _____ (Time) _____ (Pager)

Please Note: The following is required before an official review will occur:

❑ Original Report/s

❑ Radiologist Approval: _____ (Print Name) _____ (Signature) _____ (Date) _____ (Time) _____ (Pager)

Outside Image(s) Upload to PACS: ❑ Routine (Up to 2 weeks) ❑ Urgent (2-3 days) ❑ Stat (within 24hrs)

Please specify the nature of any Urgent or Stat requests: _____

Comments:

Specify modality, body part or region, and originating facility to be uploaded to PACS per CD submitted.
If submitting films, pull relevant film/s for interpretation and/or comparison and attach them to the request form.

Modality	Body Part / Region	Originating Facility / Hospital
1.		
2.		
3.		
4.		

DIAGNOSIS / HISTORY:

Signs and Symptoms:

_____

_____

_____

Please leave contact name and number for imaging pick-up contact person.

Contact Name: _____ _____ (Office Phone #) _____ (Cell #)

Signature: _____ (Print Name) _____ (Signature) _____ (Date) _____ (Time) _____ (Pager)

Processing turn around time not to exceed 2 weeks.
You will be contacted by the Image Library if any submitted CDs are not computer software compatible.
Any incomplete section of the form will delay the processing of the request.

100-1482 (6/10)

S-FF (Internal Use Only): _____