

STANFORD RADIOLOGY SCHEDULING CENTER

Tel: (650) 723-6855 Fax: (650) 723-6036

Scheduling Hours: Monday – Friday 7:30am – 6:00pm

Website: <http://stanfordhealthcare.org/imaging>



Stanford
HEALTH CARE

Last Name: _____ First Name: _____ Male Female Other
 Address: _____ Phone # _____ Cell # _____
 MRN: _____ Date of Birth: _____ Weight # _____ (Required for MRI & CT)
 Specify special scheduling needs (e.g. translator): _____ **IS PATIENT PREGNANT?** Yes No N/A
 Please provide Pre-Authorization Assistance for (MRI, CT, PET/CT, PET/MR) (*Please Fax Card*): Yes No
 Insurance Provider & Policy # _____ Authorization # _____ No Authorization Required

Clinic/Office: _____ Phone # _____ Fax # _____ Pager # _____
 Ordering Physician: _____ Signature _____ Print Name _____ Date _____
 Attending: _____ Print Name _____ Office Contact: _____ Print Name _____
 STAT Reading Contact By: Phone _____ Cell _____ Fax _____
 Routine Preferred Date: _____ Preferred Location: _____

DIAGNOSIS: (Required) PLEASE FAX CLINICAL NOTES IF APPLICABLE
 ICD Code/s: _____
 Signs and Symptoms: _____
 History: _____

Specify Body Part or Region to Be Examined (Please indicate Routine and/or Special Studies): Left Right Bilateral
 1. _____
 2. _____

Diagnostic (General Radiography)
 CT (Computed Tomography) **CT Angiography** **3D Reconstruction**
 MRI **MRI Arthrogram** **MR Angiography** **3D Reconstruction**
 Ultrasound
 Interventional Radiology (CT-Guided and Angiographic Procedures) **Call to Schedule at 650-736-9081**
 Mammography (2D and 3D/Tomosynthesis Available)
Mail prior films to: Stanford Health Care, Radiology 875 Blake Wilbur Drive, Rm CC1204, Stanford, CA 94305. Image Library (650) 723-6717
 Screening Screening to Diagnostic mammogram with ultrasound, if clinically indicated and biopsy, if clinically indicated
 Diagnostic mammogram with ultrasound, if clinically indicated and biopsy, if clinically indicated
 Diagnostic Ultrasound History/Clinical: _____
 Mammographic Procedure Type
 Ultrasound Guided Core Biopsy Stereotactic Core Biopsy Fine Needle Aspiration Needle Localization
 Nuclear Medicine Sentinel Node Imaging HIDA Octreoscan Gastric Emptying: Liquid Solid
 Thyroid study Myocardial Perfusion: Exercise Pharmacologic
 Bone Scan Bone Densitometry MIBG WBC scan VQ scan Brain Perfusion
 PET/CT Staging: (Required) PI (initial treatment strategy) PS (subsequent treatment strategy)
 Whole Body: Skull base to mid-thigh Vertex to toes Cardiac: Viability Sarcoid
 NaF Skeletal PET Ga-68 DOTA TATE (NET) Axumin (Fluciclovine)
Diagnostic CT Options (added to PET/CT): Neck Chest Abdomen Pelvis Other _____
 PET/MR Staging: (Required) PI (initial treatment strategy) PS (subsequent treatment strategy)
 Brain: Memory-FDG Memory-Amyloid Epilepsy-FDG Tumor-FDG
 Whole Body: FDG Ga-68 DOTA TATE (NET)
Diagnostic MR Options (added to PET/MR): Brain Head/Neck Chest Abdomen Pelvis Other _____
 GI Procedures / HSG (Hysterosalpingogram)
 Fluoroscopy Procedures
 Other _____

Required for MRI/CT: (Unavailability of a required serum creatinine or non-premedication of a contrast allergic patient may result in rescheduling of a patient.)

CREATININE LEVEL _____ mg/dL **Required for**
Date Drawn _____ **MRI/CT/Arthrogram/HSG:**
 Creatinine level within 30 days of exam date for: History of Contrast Allergy Yes No
 ~ Patient age 70 or older (CT/MRI) Premedication ordered Yes No
 ~ Diabetes (insulin and non-insulin dependent)
 ~ Renal disease/single kidney

STANFORD HEALTH CARE
 STANFORD, CALIFORNIA 94305



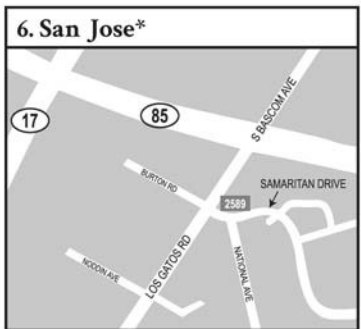
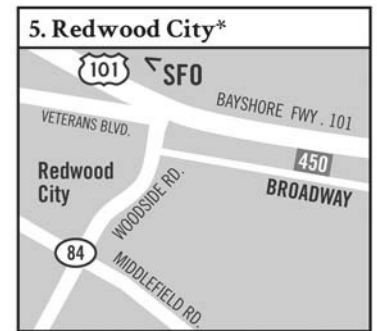
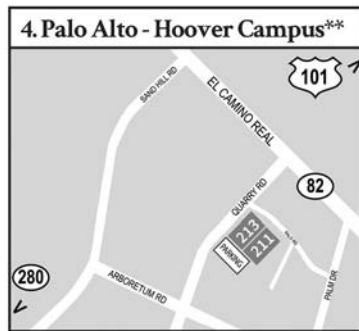
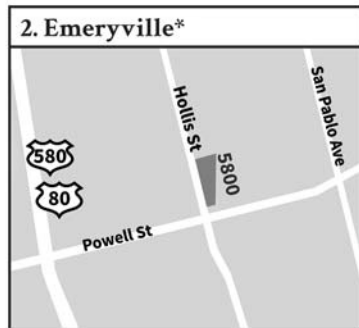
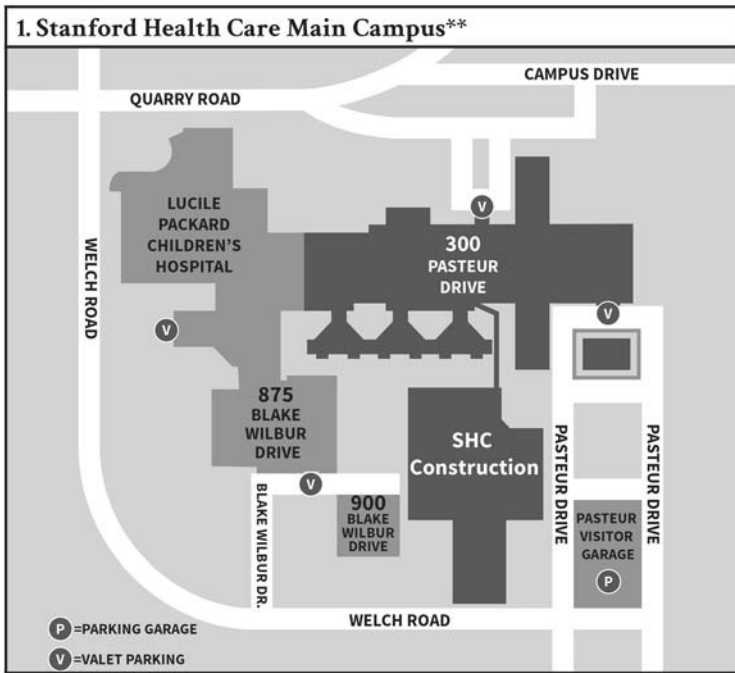
ORDERS • RADIOLOGY REQUISITION

MESSAGE TO PHYSICIANS: Medicare will only pay for services that are reasonable and necessary for the diagnosis and treatment of the patient. The Physician must specify an ICD diagnosis code to indicate the medical necessity of each test requested. Medicare and other carriers may not pay for screening tests or tests that are not FDA approved. If there is reason to believe that a carrier will not pay for the test, the patient should be informed and asked to sign an Advanced Beneficiary Notice (ABN) indicating acceptance of responsibility for the cost of the test if the carrier denies payment.

RADIOLOGY PROCEDURE REQUESTED
 Physician to Physician Radiology Consult Line (650) 736-1173

	City	Imaging Center	Address	3T MRI	1.5T MRI	CT	Ultrasound	X-Ray (Walk In)	Mammo (2D & 3D/Tomo)	DEXA/ Bone Density	Nuclear Medicine	PET/CT	PET/MR	Fluoroscopy	Musculoskeletal Procedures
1	Stanford Health Care Main Campus	Hospital 300P	300 Pasteur Drive Stanford, CA 94305	✓	✓	✓	✓	✓		✓	✓	✓		✓	
1	Stanford Health Care Main Campus	Hospital 500P	500 Pasteur Drive Stanford, CA 94305	Coming 2019											
1	Stanford Health Care Main Campus	Blake Wilbur Outpatient Clinic	900 Blake Wilbur Drive Stanford, CA 94305	✓	✓	✓	✓	✓	S, 3D						
1	Stanford Health Care Main Campus	Advanced Medicine Center	875 Blake Wilbur Drive Stanford, CA 94305	✓				✓	S/D, 3D						
2	Emeryville	Stanford Health Care at Emeryville	5800 Hollis St. Emeryville, CA 94608	✓		✓	✓	✓	S, 3D	✓	✓				
3	Palo Alto	Stanford Medicine Imaging Center	451 Sherman Ave. Palo Alto, CA 94306	✓		✓									
4	Palo Alto - Hoover Medical Campus	Hoover Pavilion 1	211 Quarry Road Palo Alto, CA 94304					✓	S, 3D						
4	Palo Alto - Hoover Medical Campus	Stanford Neuroscience Health Center	213 Quarry Road Palo Alto, CA 94304	✓		✓	✓						✓		
5	Redwood City	Stanford Medicine Outpatient Center	450 Broadway St. Redwood City, CA 94063	✓		✓	✓	✓		✓					✓
6	San Jose	Stanford Cancer Center South Bay	2589 Samaritan Drive San Jose, CA 95124	✓		✓	✓	✓	S/D, 3D			✓			

For additional information on driving, parking directions and parking rates, please visit: <https://stanfordhealthcare.org/directions>



S = Screening Mammography
 D = Diagnostic Mammography
 2D = Mammography
 3D = Tomosynthesis ("3D" Mammography)

*Free self parking is available. **Parking fees apply.

