Last Name: ___________________  First Name: ___________________  □ Male  □ Female  □ Other
Address: ___________________  Phone #: ___________________  Cell #: ___________________
MRN: ___________________  Date of Birth: ___________________  Weight #: ___________________  (Required for MRI & CT)
Specify other considerations (e.g. interpreter): ____________________________________________________________
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

□ CT  □ Diagnostic X-ray  □ Fluoroscopy Procedure  □ MRI  □ Ultrasound  □ 3D Reconstruction
□ GI Procedure  □ HSG (Hysterosalpingogram)
□ Breast Imaging (DBT = 3D-Like Digital Tomosynthesis), MG = Mammogram, Diag = Diagnostic, US = Ultrasound
   □ Screening DBT MG to Diag DBT MG with Diag Targeted US, if clinically indicated and biopsy, if clinically indicated
   □ Screening DBT MG Automated Whole Breast US (Available only at the Advanced Medicine Center in Palo Alto)
   □ Diag DBT MG, with Diag Targeted US, if clinically indicated and biopsy, if clinically indicated
   □ Breast MRI:  □ Breast Implant Assessment Only  □ Cancer Detection/Assessment  □ Breast Implant and Cancer Detection/Assessment
   Mail prior films to: Stanford Health Care, Radiology 875 Blake Wilbur Drive, CC1250, M/C 5828 Stanford, CA 94305. Image Library (650) 723-6717

□ Breast Imaging Procedure
   Guided Core Biopsy:  □ US  □ MRI  □ Stereotactic  Needle Localization:  □ US  □ MRI  □ Stereotactic
   □ US Fine Needle Aspiration  Scout Localization:  □ US  □ Stereotactic
   □ 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)
   □ Diagnostic CT Options (added to PET/CT):  □ Neck  □ Chest  □ Abdomen  □ Pelvis  □ Other
   □ PET/MR Staging:  (Required)
   □ PI (initial treatment strategy)  □ PS (subsequent treatment strategy)
   □ Diagnostic MR Options (added to PET/MR):  □ Brain  □ Head/Neck  □ Chest  □ Abdomen  □ Pelvis  □ Other
   □ Interventional Radiology (CT-Guided and Angiographic Procedures)  Call to Schedule at 650-736-9081

Required for MR/CT/arthrogram/HSG with IV contrast:
   History of IV contrast allergy:  Yes  □ No
If yes, referring provider must order Prednisone and Benadryl:
   Prednisone (total of 150mg PO): Take 50mg 13 hours before, 50mg 7 hours before and 50 mg 1 hour before scan time.
   Benadryl 50mg PO: Take 1 hour before scan time.
   Non-premedication of a contrast allergic patient may result in rescheduling.

ABN Message to Physician and/or SHC Radiology: 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 payors may not pay for screening tests or tests that are done for a non-covered diagnosis. If you have a reason to believe that the payor will not cover a 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 it gets denied. Please attach the ABN along with this requisition, as needed.

STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

ORDERS • RADIOLOGY REQUISITION

# STANFORD HEALTH CARE IMAGING CENTERS

## Stanford Health Care Imaging Services*

<table>
<thead>
<tr>
<th>City</th>
<th>Imaging Center</th>
<th>Address</th>
<th>3T MRI</th>
<th>1.5T MRI</th>
<th>CT</th>
<th>Ultrasound</th>
<th>X-Ray (Nail Bed)</th>
<th>DEXA/ Bone Density</th>
<th>Nuclear Medicine</th>
<th>PET/CT</th>
<th>PET/MR</th>
<th>Fluoroscopy</th>
<th>Miscellaneous Procedures</th>
<th>Image Library</th>
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<td>Emeryville</td>
<td>Stanford Health Care at Emeryville</td>
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<td>Palo Alto</td>
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<td>651 Sherman Ave., Palo Alto, CA 94306</td>
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<td>Palo Alto</td>
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<td>Stanford</td>
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S = Screening Mammogram  
D = Diagnostic Mammogram  
3D = Mammogram Tomosynthesis 3-D Like

*Exams interpreted by Stanford Medicine Faculty

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## Stanford Health Care - ValleyCare*

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<th>Image Library</th>
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<td>Stanford Health Care ValleyCare Livermore</td>
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