Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

CLINIC • IMAGE LIBRARY • UPLOAD/OVERREAD REQUEST

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

REQUEST PRIORITY: ❑ STAT (Emergency/Surgical) ❑ URGENT (within 24 hours) ❑ ROUTINE (Up to 5 days)

PHYSICIAN INFORMATION

Patient Location: _____
Clinic/In-Patient Unit

Ordering Physician: _____ _____ _____ _____
Print Name Signature Date Time

Attending/PCP: _____ _____ _____ _____
Print Name Signature Date Time

FOR OUTSIDE IMAGE UPLOAD:

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.			

FOR OFFICIAL REVIEW REQUESTS:

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

❑ Original Report/s must be available with the images.

❑ Radiologist Approval: Call *(650) 736-1173* to speak to the Radiologist.

_____ _____ _____ _____
Approving Radiologist (Print Name) Signature Date Time

DIAGNOSIS / HISTORY:

Signs and Symptoms (Be specific):

_____

_____

_____

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

Contact Name: _____ _____ _____
Print Name Phone # Cell #

Signature: _____ _____ _____
Date Time

You will be contacted by the Image Library if any submitted CDs are not computer software compatible.
Any imcomplete section of the form will delay the processing of the request.

S-FF (Internal Use Only): _____