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.

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<th>Modality</th>
<th>Body Part / Region</th>
<th>Originating Facility / Hospital</th>
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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 incomplete section of the form will delay the processing of the request.

S-FF (Internal Use Only): ____________

15-3191 (12/18)