

**Department of Radiology**  
**REFERRING PHYSICIAN FAX FORM**  
(Unknown Provider)



**If this is your first time referring to Stanford Imaging please complete this ONE TIME form for the Medical Staff Office provider data base.**

**Fax the form: 650-498-6097**  
**Attention: Referring Provider Services**

**REFERRING PHYSICIAN INFORMATION**

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE:** \_\_\_\_\_

**ZIP CODE:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_

**OFFICE FAX NUMBER:** \_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_

**NPI NUMBER:** \_\_\_\_\_

**LICENSE NUMBER:** (Note: For CA license - 5 numbers preceded by an alpha digit)

\_\_\_\_\_

**SPECIALTY:** \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Accession #: \_\_\_\_\_  
Scheduled By: \_\_\_\_\_ Scheduled Date: \_\_\_\_\_  
Radiology Scheduling Staff Use Only