

The Johns Hopkins Breast Imaging Center Consultation Form

PHYSICIAN REFERRED FORM

This form is to be completed if you wish to have a patient's mammograms and/or breast ultrasounds read and evaluated by the faculty of the Johns Hopkins Breast Imaging Center. You may also use the Maryland Uniform Consultation Form. We will read the films within 5 business days. Please complete the information below (2 pages) and mail it along with your films and reports to:

The Johns Hopkins Breast Imaging Center
Outpatient Center Room 4120C
601 North Caroline Street
Baltimore, Maryland 21287
Attention: Nagi F. Khouri, M.D.
(Please Print)

Today's Date _____

PCP: _____

PATIENT INFORMATION

LAST NAME: _____

FIRST: _____

MIDDLE: _____

Birth date:	Age:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Race:	Mother's Maiden Name (Last, First): _____
/ /				Father's Full Name: _____
Address: _____				
City: _____		State: _____		Zip Code: _____
Phone Number: Day ()				Phone Number: Evening ()

Physician Name: _____

Address: _____

Phone: () Fax: ()

(The physician will receive a report)

Mammogram Facility: _____

Address: _____

Phone: () (Return Films to Patient or Facility)

INSURANCE INFORMATION

(Please include a copy of the front and back of the patient's insurance card)

Insurance Company:	Insurance Company Address:	Policy Holder's Name:
		Policy Holder' Birth Date:
Patient's Relationship to Policy Holder:	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Policy Number:	Group Number:	Additional Information
Name of Secondary Insurance (If Applicable):	Subscriber's Name:	Group Number: Policy Number

The patient's signature below indicates that if this service is not covered by Insurance, the patient agrees to pay for the service received. The fee for this service is \$150.00
The patient must also sign the JH Insurance Waiver for us to bill the Insurance Company.

Patient Signature _____ Date _____

The Johns Hopkins Breast Imaging Center Consultation Form PATIENT REFERRED FORM

This form is to be completed if you wish to have your mammograms and/or breast ultrasounds read and evaluated by the faculty of the Johns Hopkins Breast Imaging Center. If your doctor wishes to refer you to our facility for a second reading of your mammogram or for diagnostic work up, **do not use this form, use the Physician Referred Form.** We will read the films within 5 business days of receiving them:
Please complete the information below (2 pages) and mail it along with your films and reports to:

**The Johns Hopkins Breast Imaging Center
Outpatient Center Room 4120C
601 North Caroline Street
Baltimore, Maryland 21287
Attention: Nagi F. Khouri, M.D.**

(Please Print)					
PATIENT INFORMATION					
LAST NAME:			FIRST:		MIDDLE:
Birth date: / /	Age:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Race:	Mother's Maiden Name (Last, First): <small>**Necessary to obtain a JHH Medical ID Number**</small>	
				Father's Full Name:	
Address:					
City:		State:		Zip Code:	Social Security Number:
Phone Number: Day ()				Phone Number: Evening ()	
Physician Name: _____					
Address: _____					
Phone: () _____ Fax: () _____					
(Your doctor will receive a report)					
Mammogram Facility: _____					
Address: _____					
Phone: () _____ (Return Films to Patient <input type="checkbox"/> or Facility <input type="checkbox"/>)					
FEE IS \$150.00 PAYABLE WITH THIS FORM AND FILMS					
PLEASE MAKE CHECK PAYABLE TO: THE JOHNS HOPKINS UNIVERISTY, RADIOLOGY					
CHECK NUMBER: _____					
CREDIT CARD: <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/> AMERICAN EXPRESS <input type="checkbox"/> DISCOVER					
CARD NUMBER: _____				EXP DATE: _____	
<small>DISCOVER CARD USERS: INCLUDED LAST 3-DIGITS ON SIGNATURE STRIP</small>					
Patient Signature _____ Date _____					