

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 the films and reports to:

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

(Please Print)					
Today's Date			PCP:		
PATIENT INFORMATION					
LAST NAME:			FIRST:		MIDDLE:
Birth date:	Age:	Sex:	Race:	Mother's Maiden Name (Last, First):	
/ /		<input type="checkbox"/> F <input type="checkbox"/> M		Father's Full Name:	
Address:					
City:		State:	ZIP Code:	Social Security Number:	
Phone Number: Day ()			Phone Number: Evening ()		
Physician Name: _____					
Address: _____					
Phone: ()		(The Physician Will Receive a Report)			
Mammogram Facility: _____					
Address: _____					
Phone: ()		(Return Films to Patient <input type="checkbox"/> or Facility <input type="checkbox"/>)			
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's 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:
<p>The patient's signature below indicates that if this service is not covered by Insurance, the patient agrees to pay for the services received. <i>The fee for this service is \$150.00.</i> The patient must also sign the JH Insurance Waiver for us to bill the Insurance Company.</p>					
Patient Signature _____			Date _____		

(Please Print)

PATIENT QUESTIONNAIRE

LAST NAME:

FIRST:

MIDDLE:

Why are you submitting your films for review? _____

First *mammogram*? Yes No Date of your last *mammogram*: _____

Have you had a breast *ultrasound*? Yes No When? _____ Comments: _____

Have you had a breast *MRI*? Yes No When? _____ Comments: _____

Date of last menstrual period: _____ Are you pregnant? Yes No

Have you been diagnosed with *Breast Cancer*? Yes No When? _____

Do you have any Family *History of Breast Cancer*? Yes No Please mark all that apply and include age of presentation below.

Mother Sister(s) Daughter(s) Grandmother Aunt(s) Other _____

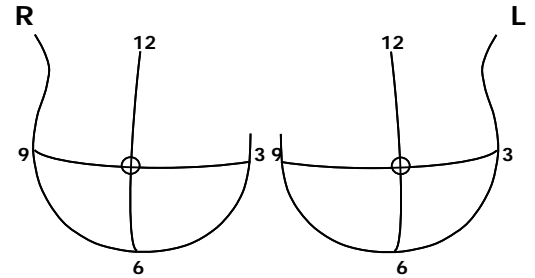
SYMPTOMS: Mark all that apply. Please be as specific as you can.

	R	L	Comment
<input type="checkbox"/> 1) Lump	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> 2) Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	Color: _____
<input type="checkbox"/> 3) Nipple retraction	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> 4) Skin thickening or retraction	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> 5) Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

IMAGING FINDINGS: Mark all that apply.

	R	L	Comment
<input type="checkbox"/> 6) Lump	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> 7) Calcifications	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> 8) Abnormal lymph node	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> 9) Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please mark the location of your symptoms / findings (numbers on the left).



Have you have had any of the following done to your breasts? Mark all that apply. Please be as specific as you can.

	R	L	When?	Comment
<input type="checkbox"/> Surgery (lumpectomy for cancer)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Surgery (excisional biopsy with benign result)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Needle biopsy (Stereotactic / Ultrasound)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Implants	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Breast reduction	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Please feel free to add any additional clinical information you consider relevant:

