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: ☐ F ☐ M	Race:	**Mother's Maiden Name** (Last , First)):
				Father's Full Name:

Address:

City:	State:	Zip Code:	Social Security Number:
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: ☐ Self ☐ Spouse ☐ 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: ☐ F ☐ M	Race:	**Mother's Maiden Name** (Last , First)): "Necessary to obtain a JHH Medical ID Number"
				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 ☐ or Facility ☐)

FEE IS $150.00 PAYABLE WITH THIS FORM AND FILMS

PLEASE MAKE CHECK PAYABLE TO: THE JOHNS HOPKINS UNIVERISTY, RADIOLOGY

CHECK NUMBER: _____

CREDIT CARD: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

CARD NUMBER: _____ EXP DATE: _____
DISCOVER CARD USERS: INCLUED LAST 3-DIGITS ON SIGNATURE STRIP

Patient Signature _____ **Date** _____