

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: _____	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: _____	<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 _____					