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 4120E
601 North Caroline Street
Baltimore, Maryland 21287
Attention: Susan Harvey, 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** ______