JOHNS HOPKINS HOSPITAL

REQUEST FOR RADIOLOGY SECOND OPINION FROM NON-JH PROVIDERS

PRINT CLEARLY (* Required Information)

***Patient's Name (Last, First, MI)** _____

JH Medical Record Number _____ *** Date of Birth** _____
(if available)

REQUEST FOR SERVICE

EACH STUDY DATE SHOULD BE ENTERED ON A SEPARATE LINE.

The requesting provider is responsible to notify his/her patient that a minimal fee is associated with requests for a second opinion and storage of images on the archive.

*Origin of outside films and/or CDs_____ICD10 Code _____

*If images are not being submitted on physical media, were images uploaded via Ambra image sharing? **Yes** ☐ **No** ☐

*Clinical/Diagnosis ***include any specific clinical information*** _____

*Study Description	*Modality	* Report Included (Y/N)	*Date of Study	Accession Number (completed by eRad Center Staff)
1.				
2.				
3.				
4.				
5.				

Provider's signature_____ **Date: ____ /____ / ____**

(Please Print)
Treating/Referring Provider Name: _____

Name of Practice: _____

Street Address:_____Suite: _____

City:_____State:_____Zip: _____

Office Phone: (____) ____-_____Office Fax: (____) ____-_____

E-mail Address: _____

I acknowledge that I am a licensed provider in the state in which my practice is located AND in which the patient resides.