



JOHNS HOPKINS HOSPITAL

**REQUEST FOR RADIOLOGY
OUTSIDE IMAGE CONSULTATION**

Section completed by Customer Service Staff

Received by (CSC initials) _____

Date & time received in CSC _____

Outside images picked-up - customer's signature & date _____

PRINT CLEARLY

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

JHH Medical Record Number _____ Date of Birth _____

ONLY REQUIRED IF PATIENT IS NOT REGISTERED IN EPIC OR SELF-REFERRAL

Patient address _____ Phone # _____

Payor Information _____

REQUEST FOR SERVICE

EACH STUDY DATE REQUIRES SEPARATE REQUEST, ALONG WITH OUTSIDE RADIOLOGY REPORT

Origin of outside films and/or CDs _____ Requested date _____

Clinical/Diagnosis *include any specific clinical information* _____

Study(s) Submitted	CD or Film	# Images or Films	Modality	Outside Report	Date of Study	Accession Number

To ensure the highest quality of customer service, please read the following information carefully.

1. Check if your patient is from the ED or scheduled for the OR, within the next hour
2. Radiology estimates that about 15% of CDs cannot be imported into UltraVisual. When this occurs, the order form will be viewable in UltraVisual with the imprint "VIEW ONLY" on the form.
3. In the event the CD cannot be imported, do you still request the consultation read? **Yes No**
4. In the event the CD cannot be imported, you will be notified to pick-up the CD immediately. CSC is not responsible after two weeks for storage of CDs or films. Please indicate how you would like to be contacted.

E-mail address _____ **Cell phone/beeper** _____ **Office number** _____

5. **The requesting physician is responsible to notify his/her patient that a minimal fee is associated with requests for an outside consultation and storage of images on the archive.**

Requesting physician's signature _____ **Code**

COMPLETED BY CUSTOMER SERVICE CENTER STAFF

CD copied at time of order Yes No Requestor _____ Date/Initials _____	Destruction of Hard Copies
VIEW ONLY CD Yes No If yes, delivered to _____ Date/Initials _____	1 st Date/Initials Contact name & method
ICD Code _____ Additional Comments _____	2 nd Date/Initials Contact name & method
	Final Date/Initials Contact name & method