



JOHNS HOPKINS HOSPITAL

REQUEST FOR RADIOLOGY OUTSIDE IMAGE CONSULTATION

Date _____
Time _____

PRINT CLEARLY

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

JHH Medical Record Number _____ Date of Birth _____

ONLY REQUIRED IF SELF-REFERRAL

Address _____ Phone # _____

Payor Information _____

EACH STUDY DATE REQUIRES SEPARATE REQUEST & OUTSIDE IMAGES REQUIRE RADIOLOGY REPORT

Origin of outside films and/or CDs _____

Clinical/Diagnosis include any specific clinical question requiring attention _____

ICD9 Code: _____

Requesting Physician _____ Code [] [] [] [] [] []

Contact Numbers Phone () _____ Beeper _____ Office _____

In the event the CD cannot be imported into the archive, do you still request a consultation read? Yes [] No []

REQUEST FOR SERVICE

Table with 7 columns: Study(s) Submitted, CD or Film, # Images or Films, Modality, Outside Report, Date of Study, Accession Number

Do you request the outside images returned requester? (Please read Radiology Return Policy) Yes [] No []

Authorize permission to destroy outside images after images are imported to Radiology archive? Yes [] No []

Requesting Physician Signature _____ Requested Date _____

COMPLETED BY CUSTOMER SERVICE CENTER STAFF

Outside Report Included - Yes [] No []

Read Only CD - Yes [] No [] Delivered to: _____ Date _____

Customer request for specific radiologist for image consultation read _____

Correct Charge Modifier selected? - RO []

Additional Comments: _____