JOHNS HOPKINS HOSPITAL

REQUEST FOR RADIOLOGY OUTSIDE IMAGE CONSULTATION

Received by (eRadiology Center Staff Initials) _______

PRINT CLEARLY (* Required Information)

***Patient's Name (Last, First, MI):** ____

***JHH Medical Record Number:** ____

***Date of Birth:** ____________________ **Date of Request:** ___________________

REQUEST FOR SERVICE

EACH STUDY DATE &STUDY REQUIRES A SPERATE LINE ON THE REQUEST, ALONG WITH THE OUTSIDE RADIOLOGY REPORT
The requesting physician is responsible to notify his/her patient of that a minimal fee is associated with the request for an outside consultation and storage of the images on the JHH Image Archive.

Clinical/Diagnosis *include any specific clinical information:

____

____

ICD9 CODE:

____

Note for Radiologist:

____

*Origin of outside films and/or CDs ____

*Study(s) Submitted	*CD or Film	# Images or Films	*Modality	*Outside Report	*Date of Study	Accession Number (completed by eRad Center Staff)
1.						
2.						
3.						
4.						
5.						

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

1. Is this patient currently in the **ED? No** ☐ **Yes** ☐ Is this patient scheduled in **OR**, within the next hour? **No** ☐ **Yes** ☐

2. Is this request need for a conference? **No** ☐ **Yes** ☐ **Date** _______________

3. Radiology estimates that about 5% of CDs cannot be imported into the JHH Image Archive. When this occurs, the order form will be viewable in UltraVisual with the imprint "READ ONLY" on the form. There will be no images available on the JHH Image Archive; a Radiology Consultation Read will be available in EPR.

   ***In the event the CD cannot be imported, do you still request the consultation read? No** ☐ **Yes** ☐

4. You will be notified via e-mail to pick-up the CD/Films once the request is completed. **The eRadiology Center is not responsible after 14 days for storage of CDs or films.** Please provide your contact information, **PRINT CLEARLY**.

***E-mail address (PRINT)** ________________________________@jhmi.edu **Cell/Pager number** ____________________

***Name of person dropping off request** ______________________, ______________________ ***Office number** ___________

Last Name First Name

***Requesting physician's signature** ____ ***Code** ☐☐☐☐☐

Completed by eRadiology Center Staff

COMPLETED BY ____________________ DATE ____________ EMAILED LEFT MESSAGE PAGED ____________________________

VIEW ONLY CD Yes No If yes, delivered to _____________________________ Date/Initials ___________________ ICD Code ____________

Additional Comments ____