Johns Hopkins Surgery
Medical Second Opinion Program

Consultation Request Form

Name of Patient: _____

I request Johns Hopkins to provide a medical second opinion for the above-named patient. My patient and I have discussed this request and understand the risks and limitations of this service. I agree to provide my patient with copies of their medical records and any other relevant diagnostic reports or studies. I also understand I will receive a copy of the assessment and recommendation and will review it with the above-named patient as I deem appropriate. I also acknowledge that I am a licensed physician in the state in which my practice is located AND in which the patient resides.

PHYSICIAN SIGNATURE _____**DATE:** ____ **/** ____ **/** ____

(Please Print)
Treating/Referring Physician Name:
_____

Name of Practice:
_____

Street Address: _____

Suite: _____

City: _____ **State:** _____ **Zip:** _____

Office Phone: (_____) _____ - _____ **Office Fax:** (_____) _____ - _____