

## Jacqueline M. Wilentz Comprehensive Breast Center

### Film Consultation / Second Opinion Instructions

Dear Patients,

Thank you for choosing the Jacqueline M. Wilentz Breast Center for your Film Consultation and/or Second Opinion

Film consults are not a scheduled appointment therefore we **can only accept them weekdays from 8:30am – 3:30pm** and **you will be here for approximately 30 minutes**.

To process your film consultation you must provide all required information and documents. If there is information missing your consultation will not be processed until the necessary information is received. Once the radiologist has reviewed your imaging we will contact your referring physician and you with her recommendations. At that time, please contact your referring physician to discuss the recommendations.

#### **Please follow the instructions listed below:**

1. Complete middle section in bold print only on page 1 (Outside Film Review Form).
2. Complete all fields on page 2 (Patient Demographic Data Form) – this information is necessary to register you into our system.
3. Complete history on page 3 (Patient History Form).
4. For Non-Medicare patient, read/review the Waiver Notice and complete outlined section on page 4, and ignore page 5.
5. For Medicare patient, ignore page 4, and read/review and complete the ABN form on page 5.
6. Page 6 (Procedure Cover Sheet) is for breast center staff, so please keep it in the packet, but you can leave it blank.
7. Complete all fields on this page 7 (Film Dropped Off Form). It is very important not only that you have all of your films but also the reports to go with them.

#### **After reading and completing the above listed forms, provide the receptionist with the following required documents:**

1. Prescriptions from your referring physician stating: Film Consultation, Surgical Consultation and/or Second Opinion.
2. Referral from your primary care physician or OBGYN if your insurance company requires one. Contact 800 number listed in your insurance card. (HMO or POS)
3. Insurance Card
4. Form of Identification (ex: drivers license, county ID, voter registration card)

**Reminder: Our office will contact your referring physician and you with results and/or recommendations from our Breast Radiologist within 3 weeks.**

Thank you for your cooperation and patience.

Jacqueline M. Wilentz Comprehensive Breast Center Staff  
300 Second Avenue, Long Branch, NJ 07740  
732-923-7700

**Jacqueline M. Wilentz Comprehensive Breast Center**

**Outside Film Review Form**

(To be completed by patient requesting consult)

Highlight any special instructions: ASAP per Dr. \_\_\_\_\_

For Dr. Staiger to read

For Dr. Shariff to read

**Please fill out all questions in bold print only.**

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_      **Phone # :** \_\_\_\_\_

**Date films dropped off** \_\_\_\_\_      **Dr. Name** \_\_\_\_\_

Recommendation by radiologist

Date reviewed \_\_\_\_\_

Reviewed by:    MS                      YS

Further studies needed now:

- |                     |   |   |
|---------------------|---|---|
| Mag Views           | L | R |
| Cone Views          | L | R |
| Ultrasound          | L | R |
| Needle Loc          | L | R |
| Stereotactic Biopsy | L | R |
| U/S guided biopsy   | L | R |

Internal follow up films:

- |            |   |   |
|------------|---|---|
| Mammogram  | L | R |
| Mag Views  | L | R |
| Cone Views | L | R |
| Ultrasound | L | R |
| Other      | L | R |

- \_\_\_\_\_
- 3 months
- 6 months
- 1 year
- Other

Dr.'s office notified of results of review:

Yes      Notified by : \_\_\_\_\_

Date : \_\_\_\_\_

No

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Jacqueline M. Wilentz Comprehensive Breast Center**

**Patient Demographic Data Form**

PATIENTS LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ M: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME # \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ WORK # \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ CELL# \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

RELIGION: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

MARITAL STATUS: S / M / W / D

EMPLOYER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ STATUS: FULL / PART / RETIRED: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION:**

INS. CO. NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

SUBSCRIBER: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ LENGTH OF EMPLOYMENT: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION:**

INS. CO. NAME: \_\_\_\_\_ ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

SUBSCRIBER: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ LENGTH OF EMPLOYMENT: \_\_\_\_\_





**Jacqueline M. Wilentz Comprehensive Breast Center**

**Procedure Cover Sheet**

(Internal staff usage only. Please keep this page within the package, but leave the content blank.)

Date: \_\_\_\_\_ Time: \_\_\_\_\_ MR#: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Referring MD: \_\_\_\_\_

Screening  
Call Back

Film Consult  
Call Back

Diagnostic  
Call Back

Outside  
Call Back

\_\_\_\_ Initials of JMWCBBC Radiologist recommending biopsy: \_\_\_\_\_



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Film Dropped Off Form

Date to drop off films: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ Date of Service done at JMWCB: \_\_\_\_\_

Please check the reason for drop off:

- 1. For comparison with Mammogram / Ultrasound
2. For radiologist to review / film consultation
3. Patient having a procedure
4. Patient returning films back to film Library

Please complete the following information (check off the type of imaging performed. If included with report write in date & the name of facility the imaging was performed for each exam you are dropping off):

Mammo \_\_\_ U/S \_\_\_ Report \_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

Mammo \_\_\_ U/S \_\_\_ Report \_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

Mammo \_\_\_ U/S \_\_\_ Report \_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

Mammo \_\_\_ U/S \_\_\_ Report \_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

Mammo \_\_\_ U/S \_\_\_ Report \_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

Mammo \_\_\_ U/S \_\_\_ Report \_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

Mammo \_\_\_ U/S \_\_\_ Report \_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

Mammo \_\_\_ U/S \_\_\_ Report \_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_

I hereby confirm by signing this form that all the information dropped off are correct and complete.

If any information is missing, you will be contacted. We cannot proceed to process your request until all the necessary information is obtained.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Number: \_\_\_\_\_