



December 4, 2006

Johns Hopkins Medicine International has developed a process to handle requests for medical second opinions. We have been managing requests for several years and have designed this process to better serve your medical needs.

The purpose of the medical second opinion program is to provide information to the patient or the local treating physician, so that an informed decision can be made in managing the patient's healthcare needs. This program aims to provide an alternative to traveling at this time to the United States for care. However, should the patient travel to Johns Hopkins for care in the future, Johns Hopkins Medicine International will make all necessary arrangements.

**To begin the medical second opinion process, please complete the following steps:**

1. Complete pages 3 through 6 of this MSO packet.
2. Gather the most recent medical records **in English.**
  - A. Radiology**—Radiology images are required for most clinical specialties. Please send hard copies of the patient's films.
  - B. Pathology (optional)**—The patient has the option of having his or her pathology specimen reviewed by a Johns Hopkins pathologist. The review of stained slides is included in the cost of a complex consultation. Unstained slides and/or blocks require an additional charge of US\$625.00. In order to avoid a delay at U.S. customs, please write the following on the pathology slide/block commercial invoice: *"Slides and/or paraffin blocks of non-infectious and non-contagious human tissue taken from the \_\_\_\_\_ (organ/tissue) which are fixed and/or preserved in paraffin. This specimen has never been cultured. It is for review by the Department of Pathology at Johns Hopkins Hospital, Baltimore, MD. The value is US\$1.00."*
3. Forward via fax, international courier, or email the completed MSO packet and medical records to:

Johns Hopkins Medicine International  
Medical Second Opinion  
601 North Caroline Street Suite 1080  
Baltimore, MD 21287  
Fax #: +1.410.502.5909  
Email: [medicalsecondopinion@jhmi.edu](mailto:medicalsecondopinion@jhmi.edu)

- . In order to expedite the process, we appreciate receiving records and forms in a single fax, package, or email.

**Once the packet is received:**

1. We will review the information and charge the credit card noted on the Credit Card Authorization Form. The medical second opinion process will not begin until our office deems the information received adequate and complete. The medical second opinion consult will be based on the information that is sent, so it is essential that the documents are accurate and as up-to-date as possible.

2. We will regularly update you on the progress of the medical second opinion. Please note that our hours of operation are Monday-Friday, 7:30am-5:00pm Eastern Time (ET). During these hours, we will respond promptly to any questions or concerns.
3. If we receive additional medical records and/or questions after the physician has started the review, an extra charge will apply.
4. Upon completion of the medical second opinion, the patient's case will be closed. If the patient would like to schedule an in-person consult with a Johns Hopkins physician, the case will be forwarded to Johns Hopkins Medicine International Patient Services.
5. No medical information provided by the patients will be returned upon completion of the medical second opinion, unless requested by the patient, in which case an additional processing fee of US\$75 will be charged. After six months of inactivity, medical records will be appropriately discarded.

The cost of this service is determined by the complexity of the case and the preferred format of the medical second opinion. The cost typically ranges from US\$500 to US\$1500.

We look forward to helping you obtain the best medical expertise here at Johns Hopkins.



**TELEMEDICINE CONSENT FORM**

I have requested that Johns Hopkins Medicine International, LLC ("JHI") arrange a telemedical consult for me regarding the condition described below with a physician employed by The Johns Hopkins University ("JHU"). Via this consult, JHI will provide me with the conclusions of the JHU physician. The JHU physician will reach those conclusions based solely on the information provided by me or my physician to JHI. Neither JHI, JHU nor any of their affiliates (collectively, the "Hopkins Parties") shall have any liability or responsibility for the accuracy or completeness of that information or for any errors in its transmission.

By providing the JHU physician's conclusions, the Hopkins Parties do not assume any continuing responsibility for my medical care or treatment. In addition, I recognize that, without a complete in-person physical examination, the JHU physician will be limited in his or her ability to correctly assess or diagnose my condition and recommend treatment.

Although the Hopkins Parties have no obligation to obtain additional medical records or other information regarding my condition, I authorize my physician and any other person or entity to release any information pertaining to my health including health history, present complaints and laboratory and diagnostic data to any of the Hopkins Parties. The Hopkins Parties are authorized, at their election, to obtain any of such records and information.

For myself and my heirs, personal representatives, administrators, successors and assigns, I irrevocably release the Hopkins Parties and their insurers, officers, directors and employees from any and all known or unknown, foreseen or unforeseen, claims, actions or damages arising in connection with the consult or JHU physician's conclusions.

Patient's Current Diagnosis: \_\_\_\_\_.

Patient Name (please print) \_\_\_\_\_

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

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_



**DATE:**

**TO: JOHNS HOPKINS MEDICINE INTERNATIONAL Medical Second Opinion (MSO) Program**

**FROM: PATIENT / PHYSICIAN / OTHER (Please Circle One)**

**PHONE #:**

**FAX#:**

**E-MAIL#:**

### **CHECKLIST OF ITEMS**

I am sending to Johns Hopkins Medicine International MSO Program:

	<b>Yes</b>	<b>No</b>
Complete MSO Packet, pages 3 through 6	<input type="checkbox"/>	<input type="checkbox"/>
Recent Medical Report ( <b>required for all requests</b> )	<input type="checkbox"/>	<input type="checkbox"/>
Lab Test Results	<input type="checkbox"/>	<input type="checkbox"/>
Radiology (X-Ray, CT, MRI) Films and Reports	<input type="checkbox"/>	<input type="checkbox"/>
Pathology Slides and Reports	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

### **PATIENT DEMOGRAPHIC INFORMATION**

**Patient's Family Name:** \_\_\_\_\_ **Patient's Given Name:** \_\_\_\_\_

**Sex:**  Female  Male

**Date of Birth:** \_\_\_\_\_

**Patient's Address:** \_\_\_\_\_

**Patient's Phone # :** \_\_\_\_\_

**Patient's Email:** \_\_\_\_\_

**Patient's Father's Full Name:** \_\_\_\_\_

**Patient's Mother's Full Name:** \_\_\_\_\_

### **QUESTIONS FOR JHM PHYSICIAN REGARDING CURRENT CONDITION**

My questions for the Johns Hopkins Medicine Physician:

(If more space is needed, please attach an additional page to this packet. Please note that this section must be completed.)

**PATIENT'S HISTORY:**

To be completed by patient and/or guardian. Please note that information provided on this page does not substitute the need for a medical report from the local treating physician.

**Medical history of the current diagnosis:**

**Other medical conditions (past or present):**

**Current medications:**

**Family medical history:**

**Psychosocial information:**

**HOW DID YOU HEAR ABOUT THE JOHNS HOPKINS INTERNATIONAL MSO SERVICE?**

- |   |  |
|---|--|
| <input type="checkbox"/> Family/relative/friend     | <input type="checkbox"/> Advertisement     |
| <input type="checkbox"/> Return patient             | <input type="checkbox"/> JHI Employee      |
| <input type="checkbox"/> Physician                  | <input type="checkbox"/> Print Publication |
| <input type="checkbox"/> Company or employer        | <input type="checkbox"/> Had MSO from JH   |
| <input type="checkbox"/> Radio/television/newspaper | <input type="checkbox"/> Direct Mailing    |
| <input type="checkbox"/> Website/Internet           | <input type="checkbox"/> Other: _____      |



**CREDIT CARD AUTHORIZATION FORM**

As per The Health Information Privacy and Portability Act (HIPAA), the following information is strictly confidential.

I authorize Johns Hopkins Medicine International and affiliated providers to charge this credit card for the cost of a medical second opinion no greater than \$1,500. I understand that this charge will be applied to the credit card provided upon receipt of this completed form.

- American Express**                       **MasterCard**                       **Visa**

**Credit Card Number** \_\_\_\_\_ **Security Code** \_\_\_\_\_

**Expiration Date** \_\_\_\_/\_\_\_\_

**Card Holder Name** \_\_\_\_\_

**Card Holder Signature** \_\_\_\_\_

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

The security code is a 3- or 4-digit number on the back of the card, usually within the signature box.