APPOINTMENT CHECKLIST
Jefferson Breast Care Center

PRIOR TO YOUR APPOINTMENT

THE FOLLOWING INFORMATION NEEDS TO BE RECEIVED IN ADVANCE OF YOUR APPOINTMENT:

- Breast imaging studies including: mammograms, breast ultrasounds, breast MRI, and breast biopsies - reports and films requested and sent

- Pathology - reports and slides requested and sent

Please note- If all of your studies were done at Jefferson or Methodist Hospital you do not need to request reports be sent.

DAY OF YOUR APPOINTMENT

PLEASE BRING THE FOLLOWING:

- Photo identification
- Insurance cards including any prescription cards
- Referrals if your insurance requires this
- Completed new patient questionnaire

*You can expect to be at the Center with us for up to 2 hours.

CALL IF ANY QUESTIONS: Breast Care Coordinator # 215-955-5120
Patient Name: ____________________________ Date: ________________
Address/City/State/Zip: ________________________________________
Sex: ___ Age: _____ Date of Birth: ____________________________ Soc. Sec. #: ____________________________
Home Phone: ____________________________ Work Phone: ____________________________ Cell Phone: ____________________________
Preferred Email Address: ______________________________________
Race: □ African American or Black □ Asian □ Native Hawaiian or other Pacific Islander □ American Indian or Alaska Native
□ Caucasian or White □ Unknown □ Declined
Marital Status: □ Married □ Divorced □ Separated □ Single □ Widowed □ Other: ____________________________
Spouse/Significant Other/Life Partner’s Name: ______________________________________
Do you live alone? □ Yes □ No
If no, who do you live with? □ Spouse □ Significant Other/Life Partner □ Children (# ___) □ Other: ____________________________

Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient’s bill.)
Guarantor: ____________________________ Date of Birth: ____________________________
Patient’s Relationship to Guarantor: ____________________________ Sex: ___ Soc. Sec. #: ____________________________
Address/City/State/Zip: ______________________________________
Home Phone: ____________________________ Work Phone: ____________________________ Cell Phone: ____________________________
Employer: ______________________________________
Address/City/State/Zip: ______________________________________

Emergency Contact Information
Contact Name: ____________________________ Relationship to Patient: ____________________________
Address/City/State/Zip: ______________________________________
Home Phone: ____________________________ Work Phone: ____________________________ Cell Phone: ____________________________

Insurance Information (A separate form is required for workers’ compensation, automobile liability, or legal services.)
PRIMARY CARRIER: ____________________________ Telephone #: ____________________________
Address: ______________________________________
Group/Plan #: ____________________________ ID/Cert #: ____________________________
Subscriber’s Name: ____________________________ Subscriber’s DOB: ____________________________
Relationship to Patient: ____________________________ Effective Date: ____________________________
SECONDARY CARRIER: ____________________________ Telephone #: ____________________________
Address: ______________________________________
Group/Plan #: ____________________________ ID/Cert #: ____________________________
Subscriber’s Name: ____________________________ Subscriber’s DOB: ____________________________
Relationship to Patient: ____________________________ Effective Date: ____________________________
Prescription Coverage Plan Information

Do you have prescription coverage?  □ No  □ Yes (If yes, specify below)

If no, is paying for prescription medications a problem for you?  □ No  □ Yes

Carrier: ______________________________ Subscriber: ______________________________
ID #: ______________________________ Phone #: ______________________________

Retail Pharmacy:
Name: ______________________________ Phone #: ______________________________
Address: ______________________________

Mail Order Pharmacy:
Name: ______________________________ Phone #: ______________________________
Address: ______________________________

Are your lab or x-ray studies capitated to a specific lab?  □ No  □ Yes (If yes, specify below)

Blood work: ______________________________ X-rays: ______________________________

To whom should letters be sent regarding your visit?
Please provide full and accurate information for all health care providers involved in your care.

Primary Care Provider:
Name: ______________________________ Phone #: ______________________________
Address: ______________________________

Referring Provider:
Name: ______________________________ Phone #: ______________________________
Address: ______________________________

Other Relevant Provider:
Name: ______________________________ Phone #: ______________________________
Address: ______________________________

Other Relevant Provider:
Name: ______________________________ Phone #: ______________________________
Address: ______________________________

Other Relevant Provider:
Name: ______________________________ Phone #: ______________________________
Address: ______________________________

Other Relevant Provider:
Name: ______________________________ Phone #: ______________________________
Address: ______________________________

Other Relevant Provider:
Name: ______________________________ Phone #: ______________________________
Address: ______________________________

Other Relevant Provider:
Name: ______________________________ Phone #: ______________________________
Address: ______________________________
Patient Name: ____________________________ Date of Birth: ____________________________

What is the problem for which you are being referred to us?

__________________________________________________________________________________

__________________________________________________________________________________

When was this condition first diagnosed?

__________________________________________________________________________________

__________________________________________________________________________________

Please briefly summarize what you know of the treatments you have received for this condition. Include, surgery, radiotherapy, chemotherapy, and any other treatments with dates, drugs, schedules of treatment, type of surgery and any other information you may have. (We will separately contact your referring doctor, but his/her records are a complement to your description, not a substitute):

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<thead>
<tr>
<th>Date(s)</th>
<th>Treatment</th>
<th>Description</th>
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Please list any questions you would like to be sure are addressed during your initial visit with us:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Which of the following best describes your everyday activity level? (Check one)

☐ Normal activity. Fully active, able to carry on all activities without restriction. Able to climb at least one flight of steps without difficulty and walk at least 3 to 4 city blocks without difficulty.

☐ Some symptoms but able to get around. Restricted in physically strenuous activity but able to walk and carry out light work or activities which can be performed while sitting (e.g., light housework, office work)

☐ In bed less than half of the time. Able to walk sufficiently to perform all self-care, but unable to carry out any work activities. Up and about more than half of waking hours.

☐ In bed more than half of the time. Capable of only limited self-care, confined to bed or chair more than half of waking hours.

☐ Completely bedridden or disabled. Cannot carry on any self-care. Totally confined to bed or chair.

Have you fallen in the last 3 months? ☐ No ☐ Yes

Medications

Please list all of your current medications:

<table>
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<tr>
<th>Name</th>
<th>Doses</th>
<th>Frequency taken (daily, twice a day, etc.)</th>
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</table>
Patient Name: ___________________________ Date of Birth: ___________________________

Are you allergic to any medications? □ No □ Yes

If yes, please list the medicines to which you are allergic and the reaction you experienced:

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<tr>
<th>Medicine</th>
<th>Allergic Reaction</th>
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Do you have any food allergies? □ No □ Yes

If yes, please list:

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<th>Medicine</th>
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**Past Medical History** *(Answer all questions. Check “Yes” or “No” as the question applies to you.)*

Do you have a history of any of the following medical problems?

- Anemia
- Diabetes/High Blood Sugar
- Emphysema/Chronic Bronchitis
- Cancer/Leukemia/Lymphoma
- Thyroid Disease
- Ulcers
- Easy Bleeding or Bruising
- Stroke
- Hepatitis
- Colon Polyps
- Seizures/Convulsions/Epilepsy
- Cirrhosis
- High Blood Pressure
- Multiple Sclerosis
- Kidney Disease
- Heart Attacks/Angina
- Tuberculosis
- Venereal Disease
- Rheumatic Fever
- Pneumonia
- Arthritis
- Heart Murmur
- Asthma
- Systemic Lupus Erythematosus
- Palpitations/Irregular Heart Beat
- Hay Fever
- Scleroderma
- Congestive Heart Failure
- Sinus Problems
- HIV Infection

Do you have a pacemaker? □ No □ Yes If yes what type:

Do you have a defibrillator? □ No □ Yes If yes what type/when placed:

Do you have any implanted devices? □ No □ Yes If yes what type/when placed:

Prostate Enlargement *(MEN ONLY)* □ No □ Yes Date of last PSA:

Other:

Dates of last rectal exam/sigmoidoscopy/stool blood test:

In the event that your cancer treatment interferes with your fertility (ability to have children), would you like information about fertility preservation options?

□ No □ Yes □ Not applicable (past child bearing age or previous surgical or health issue which precludes)

**Past Surgical History**

Have you undergone surgery for any reason? □ No □ Yes

If yes, please list the surgical procedure and approximately when it was performed:

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<th>Procedure</th>
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**Other:**

Dates of last rectal exam/sigmoidoscopy/stool blood test:
Breast Health

Breast Lumps ............................................. ☐ No ☐ Yes
Do you do self-breast examinations? .......... ☐ No ☐ Yes

Women Only

Current Bra Size? ____________________________

Are you pregnant? ............................................. ☐ No ☐ Yes  If yes, how many months? ______

How many pregnancies have you had? ______ How many births (babies delivered)? ______

How old were you when you became pregnant for the first time? ______

How old were you at the time of your last pregnancy (most recent pregnancy)? ______

Did you breast feed? ............................................. ☐ No ☐ Yes  If yes, for how long? ____________________________

Have you had any infertility treatments? ...... ☐ No ☐ Yes  If yes, please list type: ____________________________

Did you ever take birth control pills? ....... ☐ No ☐ Yes  If yes, for how long? ____________________________

Are you still taking birth control pills? ...... ☐ No ☐ Yes  If yes, what brand name? ____________________________

Do you/your partner practice birth control? .. ☐ No ☐ Yes  Methods used: ____________________________

Age at which your menstrual periods started: ______

Are you still menstruating? ......................... ☐ No ☐ Yes  If yes, date of last period: ____________________________

Did you have a hysterectomy? ................. ☐ No ☐ Yes  Were your ovaries removed? ☐ No ☐ Yes

Have you ever taken hormone replacement therapy? ........ ☐ No ☐ Yes  If yes, how long? ____________________________

Are you currently taking? ............................. ☐ No ☐ Yes

Dates of last pelvic exam/pap smear/breast exam/mammogram: ____________________________

Family History

Do any family members-blood relative only (Parents, Grandparents, Aunts, Uncles, First Cousins, Brothers, Sisters, or Children) suffer from the following disease?

Did your mother have breast cancer? .................. ☐ No ☐ Yes  If yes, what age? ____________________________

Did any of your sisters have breast cancer? ....... ☐ No ☐ Yes  If yes, what age? ____________________________

Did either grandmother have breast cancer?

☐ No ☐ Yes; Mother’s mother age ____________________________  ☐ Yes; Father’s mother age ____________________________

Did any aunt on either side of family have breast cancer?

☐ No ☐ Yes; Mother’s side age(s) ____________________________  ☐ Yes; Father’s side age(s) ____________________________

Did any cousin on either side of family have breast cancer?

☐ No ☐ Yes; Mother’s side age(s) ____________________________  ☐ Yes; Father’s side age(s) ____________________________

Are there any family member(s) with breast cancer?

☐ No ☐ Yes  If yes, what age? ____________________________  Who ____________________________

Are there any family member(s) with ovarian cancer? ...... ☐ No ☐ Yes  If yes, what age? ____________________________

Are there any family member(s) with colon cancer? ...... ☐ No ☐ Yes  If yes, what age? ____________________________

Are there any family member(s) with prostate cancer? ...... ☐ No ☐ Yes  If yes, what age? ____________________________
Patient Name: ___________________________ Date of Birth: __________

Other Cancers/Leukemia/Lymphoma  □ No  □ Yes  Who ___________________________
What Type ___________________________

Anemia  .................................. □ No  □ Yes  Who ___________________________

Easy Bleeding or Bruising  ............... □ No  □ Yes  Who ___________________________

High Blood Pressure  ..................... □ No  □ Yes  Who ___________________________

Heart Attacks/ Angina  ................... □ No  □ Yes  Who ___________________________

Congestive Heart Failure  ................ □ No  □ Yes  Who ___________________________

Diabetes/High Blood Sugar  .............. □ No  □ Yes  Who ___________________________

Thyroid Disease  .......................... □ No  □ Yes  Who ___________________________

Stroke  ................................... □ No  □ Yes  Who ___________________________

Multiple Sclerosis  ........................ □ No  □ Yes  Who ___________________________

Tuberculosis  ............................. □ No  □ Yes  Who ___________________________

Emphysema/Chronic Bronchitis ......... □ No  □ Yes  Who ___________________________

Hepatitis/Cirrhosis  ....................... □ No  □ Yes  Who ___________________________

Colon Polyps  ............................ □ No  □ Yes  Who ___________________________

Kidney Disease  ........................... □ No  □ Yes  Who ___________________________

Systemic Lupus Erythematosus ........ □ No  □ Yes  Who ___________________________

Scleroderma  .............................. □ No  □ Yes  Who ___________________________

Other: ___________________________

Is your father alive?  ............... □ No  □ Yes  If yes, current age ______
• If no, age and cause of death: _____________________________________________
• Comments about his health: _______________________________________________

Is your mother alive?  ............... □ No  □ Yes  If yes, current age ______
• If no, age and cause of death: _____________________________________________
• Comments about her health: _______________________________________________

How many brothers/sisters do you have?  # of Brothers: ______  # of Sisters: ______
• Ages of brothers: _________________________________________________________
• Ages of sisters: ___________________________________________________________
• Comments about their health: _______________________________________________

How many children do you have?  # of Sons: ______  # of Daughters: ______
• Ages of sons: _____________________________________________________________
• Ages of daughters: __________________________________________________________
• Comments about their health: _______________________________________________

Social History

Occupation: ___________________________________________ Number of years in this job: ______

Former jobs: Number of years: Former jobs: Number of years:
__________________________________________  ___________________________
__________________________________________  ___________________________
__________________________________________  ___________________________
__________________________________________  ___________________________
__________________________________________  ___________________________
Patient Name: ___________________________ Date of Birth: __________

Have you ever been a cigarette smoker? . . . . . . . . □ No □ Yes Packs per day: ______
  • Number of years you have smoked: ______
  • Are you still smoking? . . . . . . . . . . . . . . . . □ No □ Yes Year you quit: ______
  • Are you interested in information on smoking cessation? □ No □ Yes

Have you ever smoked a cigar or pipe? . . . . . . . . □ No □ Yes
  • Describe: ____________________________________________________________

Do you drink alcohol? . . . . . . . . . . . . . . . . . . □ No □ Yes
  • Amount/Frequency: ______________________________________________________

Do you use “recreational” drugs (circle the relevant drugs): . . . . □ No □ Yes
  • Marijuana, Cocaine, Amphetamines, Barbituates, Heroin or other Narcotics, Hallucinogens, other ________________________________
  • Have you used any of these drugs in the past? □ No □ Yes
  • Describe: ____________________________________________________________

Are there any religious, traditional, ethnic, cultural, or spiritual practices that need to be part of your care? . . . . □ No □ Yes
If yes, please specify: __________________________________________________________

Do you have any needs regarding transportation to and from your treatments? . . . . . . . . . . . . . . . . □ No □ Yes
If yes, please specify: __________________________________________________________

Decision Making:

• Do you have an advanced directive or living will? (a document that explains your wishes, if you are too ill to make medical decisions for yourself) □ No □ Yes If “Yes,” please give a copy to our office staff.

• Do you have a durable power of attorney? (a person authorized to act on your behalf, if you are too ill to make medical decisions for yourself) □ No □ Yes If “Yes,” please print the person’s name below.

(Print durable power of attorney name) ____________________________________________ Date: __________

Patient’s Signature: _______________________________________________ Date: __________________

Physician comments about medical history:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Physician’s Signature: ___________________________ Date: __________ Time: __________
### Review of Systems

Have you recently experienced any of the following problems? If so please describe.

#### General/Constitutional:

- **Fever, Chills, or Sweats**
  - [ ] No
  - [ ] Yes
  - Describe

- **Change in Appetite/Weight Loss**
  - [ ] No
  - [ ] Yes
  - Describe

- **Fatigue**
  - [ ] No
  - [ ] Yes
  - Describe

- **New Pain**
  - [ ] No
  - [ ] Yes
  - Describe

- **Changes in Pain Medication**
  - [ ] No
  - [ ] Yes
  - Describe

#### Skin & Breast:

- **Rash**
  - [ ] No
  - [ ] Yes
  - Describe

- **Itching**
  - [ ] No
  - [ ] Yes
  - Describe

- **Blisters**
  - [ ] No
  - [ ] Yes
  - Describe

- **Pain/Redness of Port/Catheter**
  - [ ] No
  - [ ] Yes
  - Describe

- **Breast Lump/Nipple Discharge**
  - [ ] No
  - [ ] Yes
  - Describe

#### Hematologic/Oncologic:

- **Swollen Glands/Lumps**
  - [ ] No
  - [ ] Yes
  - Describe

- **Bruising/Bleeding**
  - [ ] No
  - [ ] Yes
  - Describe

- **Paler than usual**
  - [ ] No
  - [ ] Yes
  - Describe

#### Neurologic:

- **Headache**
  - [ ] No
  - [ ] Yes
  - Describe

- **Numbness/Tingling**
  - [ ] No
  - [ ] Yes
  - Describe

- **Speech or Memory Change**
  - [ ] No
  - [ ] Yes
  - Describe

- **Problems with Balance/Dizziness**
  - [ ] No
  - [ ] Yes
  - Describe

- **Weakness**
  - [ ] No
  - [ ] Yes
  - Describe

#### Ophthalmologic:

- **Change in Vision**
  - [ ] No
  - [ ] Yes
  - Describe

- **Dryness/Pain/Tearing of eyes**
  - [ ] No
  - [ ] Yes
  - Describe

#### Head/Ears/Nose/Throat:

- **Hair Loss**
  - [ ] No
  - [ ] Yes
  - Describe

- **Hearing Problems**
  - [ ] No
  - [ ] Yes
  - Describe

- **Sinus Pain/Congestion**
  - [ ] No
  - [ ] Yes
  - Describe

- **Dry Mouth/Sores**
  - [ ] No
  - [ ] Yes
  - Describe

- **Sore Throat/Hoarseness**
  - [ ] No
  - [ ] Yes
  - Describe

- **Trouble Swallowing**
  - [ ] No
  - [ ] Yes
  - Describe

- **Stiff Neck**
  - [ ] No
  - [ ] Yes
  - Describe

#### Cardiovascular:

- **Chest Pain**
  - [ ] No
  - [ ] Yes
  - Describe

- **Palpitations/Irregular Heart Beat**
  - [ ] No
  - [ ] Yes
  - Describe

- **Swelling**
  - [ ] No
  - [ ] Yes
  - Describe
Respiratory:
- Shortness of Breath: □ No □ Yes Describe
- Painful Breathing: □ No □ Yes Describe
- Cough/Sputum Production: □ No □ Yes Describe
- Wheezing: □ No □ Yes Describe

Gastrointestinal:
- Stomach/Abdominal Pain: □ No □ Yes Describe
- Nausea/Vomiting: □ No □ Yes Describe
- Loose Stool/Diarrhea: □ No □ Yes Describe
- Constipation: □ No □ Yes Describe
- Blood in Stool: □ No □ Yes Describe
- Black Stools: □ No □ Yes Describe
- Describe appetite:

Genitourinary:
- Pain on Urinating: □ No □ Yes Describe
- Blood in Urine: □ No □ Yes Describe
- Trouble Initiating Urine Stream: □ No □ Yes Describe
- Awakening to Urinate: □ No □ Yes Describe
- Sexual Problems: □ No □ Yes Describe
- Vaginal Bleeding/Spotting: □ No □ Yes Describe

Musculoskeletal:
- Muscle Ache/Pain: □ No □ Yes Describe
- Joint Pain/Swelling/Stiffness: □ No □ Yes Describe
- Bone Pain: □ No □ Yes Describe
- Falls within the last year: □ No □ Yes How many? _____

Emotional:
- Anxiety: □ No □ Yes Describe
- Depression: □ No □ Yes Describe
- Trouble Sleeping: □ No □ Yes Describe

Other:
Describe other problems conditions you would like to make known to your doctor:

Patient’s Signature: ___________________________ Date: __________

Physician’s Statement:
Getting to Jefferson

Thomas Jefferson University Hospitals – Center City
Methodist Hospital
Jefferson Voorhees
Jefferson Hospital for Neuroscience
**Thomas Jefferson University Hospitals – Center City**

### By Public Transportation

**From Northeast Philadelphia**
- Take westbound Market-Frankford elevated to 11th and Market Streets.
- Walk south on 11th Street one block to the Jefferson campus at 11th and Chestnut Streets. (Consult the map on pages 6 and 7 of this booklet for on-campus directions.)

**From South Philadelphia**
- Take Broad Street subway to Broad and Locust Streets.
- Walk east on Locust Street three blocks to the Jefferson campus at 11th and Locust Streets. (Consult the map on pages 6 and 7 of this booklet for on-campus directions.)

**From West Philadelphia**
- Take the eastbound Market-Frankford elevated to 11th and Market Streets.
- Walk south on 11th Street one block to the Jefferson campus at 11th and Chestnut Streets. (Consult the map on pages 6 and 7 of this booklet for on-campus directions.)

**From the suburbs**
- Call SEPTA at 215-580-7800 to determine the regional rail line closest to your home.
- Take the train to the Market East Station at 11th and Market Streets.

**From New Jersey**
- Take the PATCO High Speed Line to the 10th and Locust Station.
- Follow signs to 10th Street; this is the corner of the Jefferson campus. (Consult the map on pages 6 and 7 of this booklet for on-campus directions.)

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**Thomas Jefferson University Hospitals – Center City**

111 South 11th Street
Philadelphia, PA 19107
Telephone: **215-955-6000**
Physician Appointments: **1-800-JEFF-NOW**

**Patient Services Department**
Room 1880, Gibbon Building
Office Hours: Monday – Friday, 8 a.m. to 5 p.m.
Telephone: **215-955-7777**
Within the hospital, dial 5-7777

**Jefferson Hospital for Neuroscience**
900 Walnut Street
Philadelphia, PA 19107
Main Number: **215-955-6000**
Physician Appointments: **1-800-JEFF-NOW**

**Methodist Hospital**
2301 South Broad Street
Philadelphia, PA 19148
Telephone: **215-952-9000**
Central Scheduling (Tests or Procedures): **215-952-1234**
Physician Appointments: **1-800-JEFF-NOW**

**Jefferson Voorhees**
443 Laurel Oak Road
Voorhees, NJ 08043
Located in the Voorhees Corporate Center
Telephone: **856-741-1000**
Physician Appointments: **1-800-JEFF-NOW**
By Car

From the Betsy Ross Bridge and points Northeast of Philadelphia
- Take I-95 South to Exit 22 (Central Philadelphia/Independence Hall/Callowhill Street).
- At the end of the ramp, turn right onto Callowhill Street.
- Continue on Callowhill Street to 8th Street.
- Turn left onto 8th Street. Follow 8th Street to Spruce Street and turn right.
- Follow Spruce Street to 11th Street and turn right. Follow 11th Street to Jefferson’s campus. Consult the parking guide in this document for a list of parking locations (including valet parking) and a campus map.

From points North and West of Philadelphia (76 East)
- Take PA Turnpike to Exit 326 (Valley Forge).
- Take 76 East (Schuylkill Expressway) to Philadelphia.
- Take Exit 344 (Central Philadelphia/676 East) – a left-lane exit.
- Take the Broad Street Exit – a right-lane exit.
- Get into left-lane and follow signs for Vine Street.
- Follow Vine Street to 10th Street and turn right onto 10th Street.
- Follow 10th Street to Jefferson’s campus. Consult the parking guide in this document for a list of parking locations (including valet parking) and a campus map.

From Northeast Extension of the Pennsylvania Turnpike (Route 476)
- Take Exit 20 and follow signs for Route 476. Take Route 476 to Exit 16A; then take Route 76 East (Schuylkill Expressway) to Philadelphia.
- Take Exit 344 (Central Phila/676 East) – a left-lane exit.
- Take the Broad Street Exit – a right-lane exit.
- Get into left-lane and follow signs for Vine Street.
- Follow Vine Street to 10th Street and turn right onto 10th Street.
- Follow 10th Street to Jefferson’s campus. Consult the parking guide in this document for a list of parking locations (including valet parking) and a campus map.

From Route 309
- Take Route 309 South to the end of the expressway.
- Turn left onto Cheltenham Avenue to Route 611 (Board Street).
- Turn right onto Route 611 South (Broad Street).
- Continue on Broad Street (approximately six miles) to Vine Street.
- Turn left onto Vine Street (outside lane) and follow to 10th Street. Turn right onto 10th Street.
- Follow 10th Street to Jefferson’s campus. Consult the parking guide in this document for a list of parking locations (including valet parking) and a campus map.

From Delaware and points South of Philadelphia
- Take Rt. I-95 North to Exit 22 (Central Phila./Independence Hall/Callowhill St.) – a left-lane exit.
- Stay in right lane and exit onto Callowhill Street.
- Once on Callowhill Street, stay in middle-lane and continue to 8th Street.
- Turn left onto 8th Street. Follow 8th Street to Spruce Street and turn right.
- Follow Spruce Street to 11th Street and turn right. Follow 11th Street to Jefferson’s campus. Consult the parking guide in this document for a list of parking locations (including valet parking) and a campus map.

From the Main Line
- Take Route 476 North to exit 16A (Route 76 East/Schuylkill Expressway) to Philadelphia.
- Take Exit 344 (Central Phila/676 East) – a left-lane exit.
- Take the Broad Street Exit – a right-lane exit.
- Stay in left-lane and follow signs for Vine Street.
- Follow Vine Street to 10th Street and turn right onto 10th Street.
- Follow 10th Street to Jefferson’s campus. Consult the parking guide in this document for a list of parking locations (including valet parking) and a campus map.
From New Jersey via Walt Whitman Bridge

- Cross Walt Whitman Bridge. After the toll booth, take I-95 North to Exit 22 (Central Phila./Independence Hall/Callowhill St.) – left-lane exit.
- At the end of the ramp, turn right onto Callowhill Street.
- Once on Callowhill Street, stay in middle-lane and continue to 8th Street.
- Turn left onto 8th Street. Follow 8th Street to Spruce Street and turn right.
- Follow Spruce Street to 11th Street and turn right. Follow 11th Street to Jefferson’s campus. Consult the parking guide in this document for a list of parking locations (including valet parking) and a campus map.

From New Jersey via the Ben Franklin Bridge

- Take bridge and stay in left-lane and turn left on 8th Street.
- Follow 8th Street to Spruce Street and turn right.
- Follow Spruce Street to 11th Street and turn right. Follow 11th Street to Jefferson’s campus. Consult the parking guide in this document for a list of parking locations (including valet parking) and a campus map.

From New Jersey Turnpike

- Take Exit 4 (73 West) off NJ Turnpike.
- Follow 73 West to 38 West.
- Continue on 38 West, following signs for the Ben Franklin Bridge. (38 West will turn into Admiral Wilson Blvd.) Continue to bridge.
- Take bridge and stay in left-lane and turn left on 8th Street.
- Follow 8th Street to Spruce Street and turn right.
- Follow Spruce Street to 11th Street and turn right. Follow 11th Street to Jefferson’s campus. Consult the parking guide in this document for a list of parking locations (including valet parking) and a campus map.

Valet Parking

Valet parking is available at three locations on campus:

- On 10th Street between Market and Chestnut Streets on the left side at the entrance to the 925 Chestnut Street building.
- On Sansom Street at the Emergency Department entrance near the corner of 10th Street.
- On 11th Street just past Sansom Street in front of the hospital.

Parking Guide

If you do not wish to use Jefferson Valet Parking Service, there are a number of parking lots and garages in the area. Patients may be dropped off at either the 11th or 10th Street entrance of the Gibbon Building.

Suggested Parking Locations
(map on following page)

A. Interpark Garage on 10th and Chestnut Streets *
   10th and Sansom Streets
B. Central Parking System (Eglin)
   Open lot between 11th and 12th on Sansom Street
C. Central Parking System (Eglin)
   12th and Sansom Street
D. Alright Parking Garage *
   12th Street between Sansom and Walnut Streets
E. Girard Square Parking
   1120 Clover Street, between Chestnut and Ludlow Streets
F. The Auto Park at Gallery Mall *
   10th Street between Arch and Filbert Streets
G. Philadelphia Parking Authority Garage *
   10th and Ludlow Streets
H. Wills Eye Hospital, Walnut Towers Garage *
   8th and 9th Streets between Locust and Walnut Streets
I. Jefferson Hospital for Neuroscience Garage *
   8th and 9th Streets between Locust and Walnut Streets
J. Walnut Street Theater Lot
   819 Walnut Street
K. Central Parking System
   Open lot between 8th and 9th Streets on Market Street *

* indicates self-park facility
Thomas Jefferson University Hospitals – Center City

**Valet Parking**

**Gibbon:** Entrance at 11th and Sansom Sts.
- Monday – Friday: 5:30 a.m. to 9 p.m.
- Saturday: 7:30 a.m. to 6 p.m.
- Sunday: 9:30 a.m. to 6 p.m.

**Emergency and Trauma Center:**
- Entrance at 10th & Sansom Sts.
- Monday – Friday: 8 a.m. to 6 p.m.

**925 Chestnut:** Entrance at 10th and Ludlow Sts.
- Monday – Friday: 7 a.m. to 5:30 p.m.

**Pharmacy**
Methodist Hospital

Methodist Hospital is just minutes from Center City and South Jersey, and is easily accessible by I-95, I-76 or public transportation.

By Car

From Center City Philadelphia
• Go south on Broad Street (PA-611) to Wolf Street.
• At traffic light turn left onto Wolf.

From Southwest Philadelphia
• Go southeast on S. 70th Street toward Passyunk Avenue.
• Turn left onto Eastwick Ave./Lindbergh Blvd.
• Turn right onto S. 63rd Street.
• Turn left onto Passyunk Avenue.
• Turn right onto Vare Ave./Oregon Ave.
• Continue straight on Oregon for about one mile. Turn left on Broad Street.
• Turn right on Wolf Street

From New Jersey via the Walt Whitman Bridge
• Take the Walt Whitman Bridge to Exit 349 (Broad Street/PA-611).
• Turn right onto Broad Street/PA-611 North.
• Cross Oregon Avenue and continue straight for four blocks. At traffic light turn right onto Wolf Street.

From Delaware and points South of Philadelphia
• Take I-95 North to Exit 17 (PA-611 N/Broad Street).
• Turn slight left onto Broad Street/PA-611 N. Cross Oregon Avenue and continue straight for four blocks. At traffic light turn right onto Wolf Street.

From points North and West of Philadelphia
• Take PA Turnpike to Exit 326 (Valley Forge).
• Take I-76 East to Exit 347B (Passyunk Ave/Oregon Ave).
• At traffic light go straight on Oregon Avenue and continue for about one mile.
• Turn left onto Broad Street.
• Turn right onto Wolf Street.

By Public Transportation

For schedules, or information to help determine your Regional Rail line or bus stop of origin, please call SEPTA at 215-580-7800.

From Center City, South and North Philadelphia
• Broad Street Subway (Orange Line) — Exit at Snyder station and walk two blocks south on Broad, or exit at Oregon and walk three blocks north on Broad.
• Bus Route C – Runs north/south on Broad Street. Exit at Wolf Street, directly across from the hospital.
• Bus Route 23 – Operates from Chestnut Hill to S. Phila. Exit at Broad and Oregon.
• Bus Route 37 – Services S. Phila. to Eastwick and Chester Transportation Ctr. via Phila. Int’l Airport. Exit at Broad and Snyder.
• Bus Route 79 – Runs crosstown from S. Phila. via Snyder Ave. Exit at Broad Street.
• Bus Route 71 (Navy Yard Shuttle) – Exit at Broad & Pattison Ave. Enter Broad Street Subway and take “local” train going Northbound to Fern Rock. Exit at Oregon station. Walk three blocks north on Broad.

From the Suburbs
• Take your Regional Rail train to Suburban Station. Follow signs in station to Broad Street Subway (Orange Line). Take the “local” train going Southbound to Pattison Avenue. End with Broad Street Subway directions above.

From South Jersey
• Take the PATCO High Speed Line to the 15-16th & Locust Station. Turn left and walk one block to the Broad Street Subway’s Walnut-Locust station. Inside, follow signs to “local” train going Southbound to Pattison. End with Broad Street Subway directions above.

Parking

The Methodist Garage is located just behind the hospital and is accessible from Wolf or Ritner Streets. It is open 24 hours a day. (See map) Metered parking is also available along Broad Street and throughout the neighborhood. There is typically a two-hour limit.
Jefferson Voorhees

Jefferson Voorhees is conveniently located in the Voorhees Corporate Center just off of Haddonfield-Berlin Road (Rt. 561), adjacent to the Ritz theater complex, only minutes from the Echelon Mall. Jefferson Voorhees offers primary care and specialty services easily accessible from Routes 295, 42, 30 or 70.

From Center City Philadelphia
- Take Benjamin Franklin Bridge to New Jersey. Once through the toll booths bear right onto Rt. 676 South (heading toward Atlantic City).
- Follow Rt. 676 South past the Walt Whitman Bridge until signs appear for Rt. 295 North (toward Trenton).
- Follow Rt. 295 North to either exit, 31, 32 or 34A. All of these exits will bring you into Voorhees (see continued directions below).

From Exit 31 / Woodcrest Station
- From 295 North, take Exit 31. Go to the end of the ramp and make a left onto Melrose Avenue. (Almost immediately, you will see Woodcrest Train Station on your right).
- Follow Melrose Avenue until it dead ends at Burnt Mill Road and make a right.
- Follow Burnt Mill Road (past the Echelon Mall on the left) until you come to White Horse Road.
- Make a left onto White Horse Road and follow this to the entrance of the Voorhees Corporate Center. (There is a Lone Star Steak house on the corner).
- Turn right onto Laurel Oak Road (pass the Hampton Inn) and continue to Jefferson Voorhees on your right. Turn right into the driveway.

From Exit 32 / Haddonfield - Gibbsboro
- From 295 North, take Exit 32. Bear to the right as you exit the ramp onto Rt. 561 East. (Rt. 561 is also known as Haddonfield-Berlin Road, or sometimes just Berlin Road.).
- Continue east on Rt. 561 for approximately three miles (until you pass the Eagle Plaza Shopping Center on the right).
- At the first traffic light past the Acme, turn right onto Voorhees Road. Follow Voorhees Road to the stop sign (you will pass the Ritz 16 movie theater on your left).
- Make a right onto Laurel Oak Road and then a quick left into the driveway for Jefferson Voorhees.

Exit 34A/Marlton
- From 295 North, take Exit 34 A. Bear to the right as you exit the ramp onto Route 70 East.
- Follow signs for South Springdale Road/Voorhees, approximately 3/4 mile. Make a right onto South Springdale Road.
- Follow this road for approximately two miles. Springdale Road will turn into White Horse Road. Bear slight right onto White Horse Road.
- Continue on White Horse Road to the entrance of the Voorhees Corporate Center.
- Make a left onto Laurel Oak Road and continue to Jefferson Voorhees on your right. Turn right into the driveway.

From Points North (Mt. Laurel, Maple Shade, Moorestown, Trenton)
- Take Rt. 295 South to Exit 32 for Voorhees. Make a left at the exit onto Rt. 561 (Haddonfield-Berlin Road).
- Continue east on Haddonfield-Berlin Road for approximately three miles until you pass the Eagle Shopping Center.
- At the first traffic light past the Acme, turn right onto Voorhees Road.
- Follow Voorhees Road to the stop sign (you will pass the Ritz 16 movie theater on your left).
- Make a right onto Laurel Oak Road and then a quick left into the driveway for Jefferson Voorhees.

From Points South (Lindenwold, Stratford, Clementon, Washington and Gloucester Townships)
- Follow College Drive / Laurel Road North until you cross over the White Horse Pike (Rt. 30). Laurel Road becomes White Horse Road at this point.
- Continue onto White Horse Road for approximately 1 mile to the entrance of the Voorhees Corporate Center which is on your right. (There is a Lone Star Steak house on the corner).
- Turn right onto Laurel Oak Rd (pass the Hampton Inn) and continue to Jefferson Voorhees on your right. Turn right into the driveway.
**From Points West (Magnolia, Barrington, Audobon, Haddon Heights)**

- Follow the White Horse Pike (Rt. 30) to White Horse Road (you must take the right jughandle to get onto White Horse Road.).
- Continue on White Horse Road for approximately one mile to the entrance of the Voorhees Corporate Center which is located on your right. (There is a Lone Star Steak house on the corner).
- Turn right onto Laurel Oak Road (pass the Hampton Inn) and continue to Jefferson Voorhees on your right. Turn right into the driveway.

**From Points East (Marlton, Atco, Berlin, Medford, Shore Points)**

- Take Rt. 73 to the Berlin Circle.
- At the Berlin Circle, take Haddonfield-Berlin Road. (Rt. 561) West towards Gibbsboro and Voorhees.
- Follow Haddonfield-Berlin Road for approximately 3½ miles to Laurel Oak Road and turn left. (The American Water Works building is at this intersection as a landmark). Jefferson Voorhees is one-quarter mile on your left. Turn left into the driveway.
Finding Your Way
Jefferson University Hospital has affiliations with the following parking garages for reduced rates:
- Hamilton Garage on 11th Street between Walnut and Locust Streets
- LAZ Parking Garage on 10th and Chestnut Streets connected via a bridge to Jefferson Hospital
- Jefferson Hospital of Neuroscience Garage on 9th Street between Walnut and Locust Streets.

Directions are available for Mobile Devices at: www.JeffersonHospital.org