

## Referral Form Breast Reduction

Due to changing insurance requirements for breast reduction surgery we are unable to schedule your patient until we receive supportive documentation. Once this information is received in our office we will gladly contact the patient and schedule a consultation.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

### Supportive Documentation **\*\*must be completed\*\***

Do you believe your patient will benefit from breast reduction surgery?  Yes  No

Do you believe that the size of your patient's breasts cause any of the following (please check all that apply):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Shoulder pain   | <input type="checkbox"/> Intertrigo of the inframammary fold | <input type="checkbox"/> Hidradenitis of the inframammary fold |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Dermatitis of the inframammary fold | <input type="checkbox"/> Ulnar nerve paresthesia               |
| <input type="checkbox"/> Neck pain       | <input type="checkbox"/> Eczema of the inframammary fold     |  |

Has your patient undergone any conservative treatment measures to relieve their symptoms? Treatments may include (check all that apply):

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> NSAIDS           | <input type="checkbox"/> Special bras           | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Chiropractic treatment | _____                                 |

For what length of time have these measures been trialed?

\_\_\_\_\_  
\_\_\_\_\_

Have other potential causes for the above conditions, unrelated to breast size, been evaluated and ruled out?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Indicate patient's BMI or include the patient's height and weight:

BMI: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**PLEASE attach any office notes in regard to the above issues that will support breast reduction surgery for insurance purposes. This includes supportive documentation from other providers such as physical therapists, chiropractors, etc.**

\_\_\_\_\_  
Primary Care Provider signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Primary Care Provider Name *(please print)*

\_\_\_\_\_  
Address:

\_\_\_\_\_  
Office Phone:

\_\_\_\_\_

\_\_\_\_\_  
Office Fax:

\_\_\_\_\_