4900 Broad Road

Syracuse, NY, 13215

Telephone: (315)299-5313

**Fax: (315)299-5661**

**Breast Reduction Fax Coversheet**

***To help us efficiently and quickly schedule a Breast Reduction consultation, please fill out this form and fax it to our office along with the requested medical records.***

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

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

 **Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Our providers require the following information:***

* **Reason for referral:**
* **The patient’s most recent BMI (Must be 39 OR BELOW)**
* **Referral must include AT LEAST 6-12 month’s worth of detailed documentation proving that a breast reduction is medically necessary and that other options have been exhausted without showing results.**

***Please check below & fax the following documentation for a consultation:***

**□Referral from PCP**

**□Patient Demographics Sheet**

**□At least 6-12 months’ worth of consistent documentation proving that breast size is causing medical issues for the patient. Ex. rashes/yeast infections under the breasts treated with prescription medications, X-ray, CT, MRI of back, neck or shoulders, PT/Chiropractor visit, etc. This is required by insurance companies for consideration of coverage.**

 **Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**