GNOSIS FOR HER
286 Winfield Circle, CA 92878
P: 714.519.6611 | F: 714.279.2020

PATIENT INFORMATION			REFERRING PROVIDER INFORMATION	
First Name:	Last Name:	MI:	Provider Name:	NPI:
DOB:	Sex: M F	Phone:	Facility/Practice Name:	
Email:			Street Address:	
Street Address:			City:	State: Zip:
City:	State:	Zip:	Phone:	Fax:

INSURANCE INFORMATION ☐ See Attached List

Insurance Name:	Policy #:	Group #:
Insured First Name:	Insured Last Name:	Relationship:
Street Address:	City:	State: Zip:

SERVICES (ALL SERVICES WITHOUT CONTRAST) (SELECT ONE SERVICE)

☐ Bilateral without contrast: 0636T ☐ Unilateral without contrast: 0633T [ ] LT [ ] RT

DIAGNOSIS CODES (ICD-10 CODES)

RISKS AND INDICIATIONS (Select all that are applicable)

History of Cancer:
- ☐ Yes ☐ No
- Date of diagnosis: _____
- ☐ Left Breast ☐ Right Breast

Breast Symptoms:
- ☐ Lump
- ☐ Pain or tenderness
- ☐ Focal pain (Location: _____)
- ☐ Nipple discharge
- ☐ Skin changes (e.g. redness, dimpling)
- ☐ Nipple inversion
- ☐ Dense breasts
- ☐ Rash
- ☐ Swelling (Location: _____)
- ☐ Thickening (Location: _____)

Risk Factors:
- ☐ Family history of cancer
- ☐ Known BRCA1 or BRCA2 gene mutations
- ☐ History of chest radiation therapy before age 30
- ☐ Certain genetic syndromes
- ☐ African descent
- ☐ Ashkenazi Jewish descent
- ☐ Age
- ☐ Estrogen levels

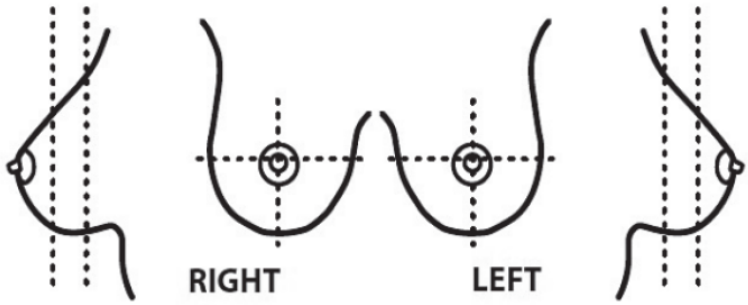
Implant Evaluation:
- ☐ Suspected rupture
- ☐ Preoperative planning
- ☐ Suspected abscess
- ☐ Implants

Follow-Up / Known Findings:
- ☐ Six-month follow-up (BI-RADS 3)
- ☐ Biopsy-proven benign mass or density
- ☐ Findings on prior Mammogram (Date: _____)

Imaging Limitations:
- ☐ Non-compliant with standard mammography

Other (Please specify):
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

AREAS OF CONCERN (Please mark all area(s))



X _____
Physician Signature and Date