gnosis for her

GNOSIS FOR HER
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E: intake@gnosisforher.com

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

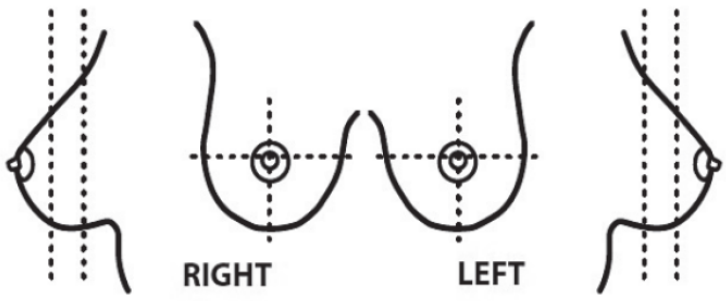
Implant Evaluation:
- ☐ Suspected rupture
- ☐ Preoperative planning
- ☐ Suspected abscess
- ☐ Implants

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))



CONFIRMATION OF INFORMED CONSENT & MEDICAL NECESSITY

The results of this test are medically necessary for the diagnosis, risk assessment, or detection of illness, disease, symptom, disorder, or syndrome. This test will produce results that will support the management and treatment decisions for my patient's condition. I hereby indicate that I am the authorized healthcare provider and referring physician for this test. I have acknowledged and support the patient's right to refuse testing and have offered the patient opportunities to ask questions as well as the opportunity to seek further counsel. The patient has chosen to take this test on their own accord and willingly selected Gnosis for Her to perform this test. I acknowledge my responsibility as the patient's physician to record all applicable ICD-10 diagnosis codes.

X _____
Physician Signature and Date