

gnosis for her

A New Diagnostic Option When Mammography Isn't Enough.



Gnosis for Her is a mobile diagnostic breast imaging provider offering 3D Breast CT to local communities. Breast CT provides true isotropic 3D visualization of the entire breast **without compression**, supporting improved evaluation in dense breast tissue, around implants, and in cases where traditional mammography is inconclusive.

Who Qualifies for Breast CT?

3D Breast CT is a diagnostic alternative, not a replacement for traditional mammography. Physicians consider Breast CT for women who:

- Have dense breast tissue or implants where traditional mammography may be limited
- Experience pain, intolerance, or delayed imaging due to compression
- Present with palpable lumps, nipple changes, or focal pain
- Prior mammography was abnormal or inconclusive
- Have a personal or family history of breast cancer
- Additional diagnostic clarity is needed before biopsy or follow-up

Why Providers Are Adopting Breast CT

Breast CT helps reduce diagnostic uncertainty when mammography is limited. For appropriate patients, it supports clearer clinical decision-making, fewer inconclusive results, and efficient coordination of follow-up, without adding unnecessary burden to the referring practice.

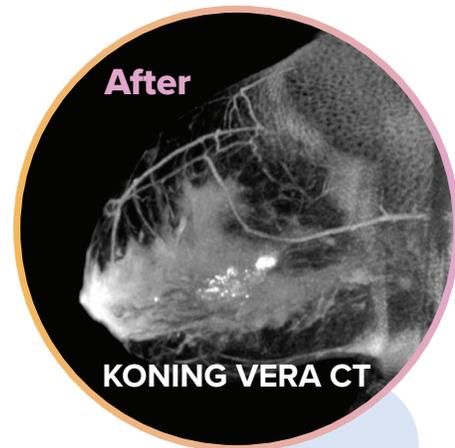
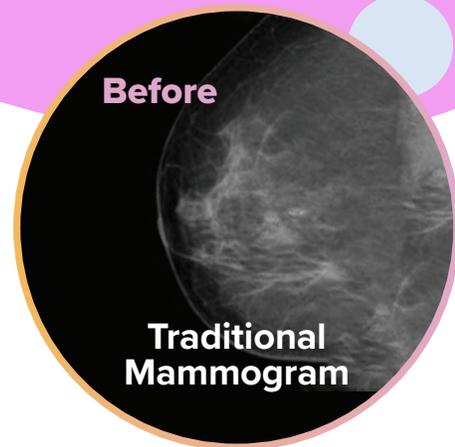
Key advantages for providers:

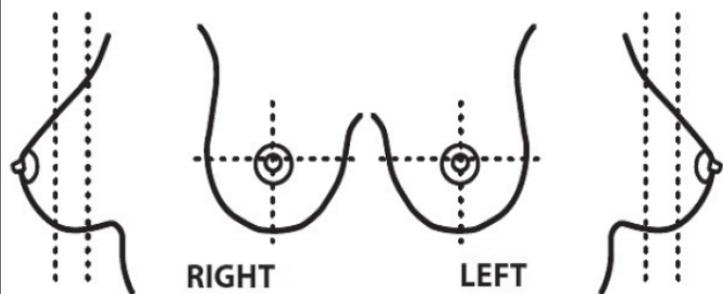
- 360° high-resolution 3D Breast CT imaging provides a complete view of the breast and surrounding areas (axilla, chest wall, and pectoralis region)
- Improved visualization in dense breast tissue, implants, and post-surgical anatomy
- <1% technical callback rate, reducing repeat imaging
- Clearer evaluation of small calcifications, smaller cancers, vascular, and subtle findings that might have been more difficult to detect by traditional mammography
- Faster and lower-cost alternative to MRI, helping reduce delays in follow-up
- High patient tolerance → improved compliance
- Radiation exposure comparable to traditional mammography

What Happens If a Follow-up Is Needed?

If further evaluation is indicated, follow-up imaging or procedures may be recommended based on clinical judgment. This may include MRI, contrast-enhanced mammography, DBT, ultrasound and ultra-sounded guided biopsies, or CT-guided intervention.

Results are communicated to both the ordering provider and the patient, ensuring timely, coordinated care.



| PATIENT INFORMATION | | | | REFERRING PROVIDER INFORMATION | | | |
|---|--|------------|------|---|--|-------------------------|------|
| First Name: | | Last Name: | | MI: | | Provider Name: | |
| DOB: | | Sex: M F | | Phone: | | Facility/Practice Name: | |
| Email: | | | | Street Address: | | | |
| Street Address: | | | | City: | | State: | Zip: |
| City: | | State: | Zip: | Phone: | | Fax: | |
| INSURANCE INFORMATION <input type="checkbox"/> 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) | | | | | | | |
| <input type="checkbox"/> Bilateral without contrast: 0636T <input type="checkbox"/> Unilateral without contrast: 0633T [] LT [] RT | | | | | | | |
| DIAGNOSIS CODES (ICD-10 CODES) | | | | | | | |
| | | | | | | | |
| RISKS AND INDICIATIONS (Select all that are applicable) | | | | | | | |
| History of Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of diagnosis: _____ <input type="checkbox"/> Left Breast <input type="checkbox"/> Right Breast | | | | Implant Evaluation: <input type="checkbox"/> Suspected rupture <input type="checkbox"/> Preoperative planning <input type="checkbox"/> Suspected abscess <input type="checkbox"/> Implants | | | |
| Breast Symptoms: <input type="checkbox"/> Lump <input type="checkbox"/> Pain or tenderness <input type="checkbox"/> Focal pain (Location: _____) <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Skin changes (e.g. redness, dimpling) <input type="checkbox"/> Nipple inversion <input type="checkbox"/> Dense breasts <input type="checkbox"/> Rash <input type="checkbox"/> Swelling (Location: _____) <input type="checkbox"/> Thickening (Location: _____) | | | | Follow-Up / Known Findings: <input type="checkbox"/> Six-month follow-up (BI-RADS 3) <input type="checkbox"/> Biopsy-proven benign mass or density <input type="checkbox"/> Findings on prior Mammogram (Date: _____) | | | |
| Risk Factors: <input type="checkbox"/> Family history of cancer <input type="checkbox"/> Known BRCA1 or BRCA2 gene mutations <input type="checkbox"/> History of chest radiation therapy before age 30 <input type="checkbox"/> Certain genetic syndromes <input type="checkbox"/> African descent <input type="checkbox"/> Ashkenazi Jewish descent <input type="checkbox"/> Age <input type="checkbox"/> Estrogen levels | | | | Imaging Limitations: <input type="checkbox"/> Non-compliant with standard mammography | | | |
| | | | | Other (Please specify): <input type="checkbox"/> _____ <input type="checkbox"/> _____ | | | |
| 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 | | | |

If your patient has not yet scheduled an appointment with Gnosis for Her, instruct them to schedule their appointment online at www.gnosisforher.com. After securing their appointment, they can upload their physician-signed requisition during registration.

If your patient already has an appointment scheduled with Gnosis for Her, your office or the patient may email the physician-signed requisition to intake@gnosisforher.com or fax it to 714.279.2020.