Plastic Surgery Clinic of Eau Claire
DR. EMBER EWINGS
3221 Stein Blvd., Eau Claire, WI 54701

BREAST REDUCTION QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

Most insurance companies are requesting 3-6 months of documented conservative therapy for symptoms associated with large breasts before they will authorize surgery. This questionnaire is to help us to provide that information to your insurance company.

Please provide the following:

☐ Letter and/or clinical notes from Primary Care Physician explaining conservative measures that have been tried and failed; noting that symptoms are due to large/heavy breasts. Letter
☐ and/or clinical notes from Chiropractor, Physical Therapist, and/or Massage Therapist explaining conservative measures.
☐ If you are over 40: Results of most current mammogram (must be within the last year).

If you have the following symptoms, please indicate with a check mark:

Bra strap irritation	____	Chest wall heaviness	____
Shoulder pain	____	Upper back pain	____
Lower back pain	____	Neck strain	____
Shoulder strap grooving	____	Rashes beneath the breasts	____
Hand tingling or numbness	____	Impediment of activities	____

Primary Care Physician: _____

Address: _____

Approximate dates of length and treatment, method of treatment: _____

_____

_____

Chiropractor: _____

Address: _____

Approximate dates of length and treatment, method of treatment: _____

_____

_____

Physical Therapy: _____

Address: _____

Approximate dates and length of treatment, method of treatment: _____

_____

Medications Tried: _____

The below information is **required** to be obtained prior to your consultation with Dr. Ewings. Any and all documented conservative therapy for symptoms associated with large/heavy breasts **must** be faxed, mailed, and/or brought with you to your appointment. This documentation is needed to contact your insurance company for prior authorization of your procedure.

- Letter and/or clinical notes from Primary Care Physician explaining conservative measures that have been tried and failed; noting that symptoms are due to large/heavy breasts.
- Letter and/or clinical notes from Chiropractor, Physical Therapist, and/or Massage Therapist explaining conservative measures.
- If you are over 40: Results of most current mammogram (must be within the last year).

Please fill out the portion below should you need to request records or notes from your treatment provider.

To Whom It May Concern:

This form is in reference to the patient below who presents to us with complaints associated with symptoms of large/heavy breasts. With your release of information regarding this patient's treatment history and medical notes, I will be able to contact their insurance company for a request for prior authorization for the breast reduction procedure. If you have any questions, please call my office at 715-833-2116.

Sincerely,
Dr. Ember Ewings

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
Patient Full Name Date of Birth

_____
Street Address City State Zip

Authorize release of records from:

_____
Provider/Physician Name Clinic

_____
Street Address City State Zip

_____
Phone Number Fax Number

Records released to: PLASTIC SURGERY CLINIC OF EAU CLAIRE
3221 STEIN BLVD. EAU CLAIRE, WI 54701
Phone: 715-833-2116 Fax: 715-833-1068

_____ _____
Signature of Patient Date Signature of Provider Date