EMORY UNIVERSITY SCHOOL OF MEDICINE | Division of Plastic and Reconstructive Surgery

BREAST REDUCTION REQUIREMENTS

Thank you for choosing Emory Healthcare. Please fax this cover sheet and ALL of the information below to plasticsurgfaxmot@emoryhealthcare.org or 404-686-4560 three days prior to your appointment to avoid cancellation.

Name: _____ DOB: _____

Scheduled Provider:

☐ Albert Losken, MD ☐ Angela Cheng, MD ☐ Heather Faulkner, MD ☐ Peter Thompson, MD
☐ Aboude Al-Nowaylati, MD ☐ Gabriela Garcia-Nores, MD ☐Daniele Cuzzone, MD ☐No Preference

(1) Mammography report (if patient is older than 40 years old)

(2) Initial office visit history and physical. Physician note must include the following as applicable:

Assessment:
- Neck/upper thoracic back pain
- Pigmentation of shoulders
- Rashes in summer months
- Grooving at shoulders
- Weight/height
- Size of breast (cup size)
- How it impacts their daily lifestyle (i.e. can't run or exercise, clothes don't fit, etc.)

Plan of care:
- Method of conservative treatment recommended: Support bra, PT, OTC analgesics, etc.

(3) Follow up office visit (60-180 days later depending on insurance plan) history and physical. Physician note must include the following as applicable:

Assessment:
- Neck/upper thoracic back pain
- Pigmentation of shoulders
- Rashes in summer months
- Grooving at shoulders
- Weight/height
- Size of breast (cup size)
- How it impacts their daily lifestyle (i.e. can't run or exercise, clothes don't fit, etc)

Plan of care:
- Method of conservative treatment tried and failed: Support bra, PT, OTC analgesics, etc.
- Referral for Breast Reduction Surgery

NOTE: The following information must be in the form of office visit notes dictated by your referring provider. Letters NOT accepted as proof of medical necessity.