Pre-Determination Planning Worksheet

Office use:
Weight:

Grams to be removed:

Breast Reduction Surgery

The information you provide will help in the medical necessity letter that will be going to your insurance company

Your insurance company, in most cases, requires medical records from providers (Doctors, Physical Therapy, Chiropractic Care, etc.) who have treated you for the symptoms listed below. It would be helpful to provide us wi supporting documentation prior to your consultation.

Patient Name_____ **Current Weight** _____ **Height** _____

Bra Size _____ **Date of last Mammogram** _____ **Location of Mammogram** _____

Check mark Symptoms you are experiencing

___Exercise Intolerance
___Poor Posture
___Breast Asymmetry
___Pendulousness
___heaviness/dense
___Upper back pain
___Shoulder pain
___Neck pain
___Bra Strap grooving
___Headaches
___Nipple-areola distortion
___Yeast Infection
___Chafing
___Itching
___Redness
___Interference with daily activities and/or work
___Respiratory difficulty

Conservative Treatment

___physical therapy
___chiropractic care
___pain medication prescription or over the counter
___muscle relaxers
___support bras
___ointments
___powders
___creams
___heat/cold pack
Misc:

Name of clinicians that have treated these symptoms: _____

Medical Records Authorization: I authorize _____ to release my medical records to Florida Plastic & Reconstructive Surgery. This information will be used on my behalf for the purposes of continuity of care.

Print Patient Name: _____ DOB: _____

Signature: _____ Date: _____