REQUEST FOR OUTSIDE IMAGES AND REPORTS

PATIENT NAME:_____

PATIENT SIGNATURE: _____

DATE OF BIRTH:_____

TYPE OF IMAGES REQUESTED: MAMMOGRAMS
BREAST ULTRASOUND

PLEASE SEND IMAGES AND REPORTS TO:

J GERSHON BREAST IMAGING
21 ARCH RD.
AVON, CT 06001

ANY QUESTIONS, PLEASE CONTACT THE OFFICE.
THANK YOU FOR YOUR ASSISTANCE.

PHONE: 860-673-8379 FAX: 860-271-8025

Image Location: _____ Faxed Date: _____