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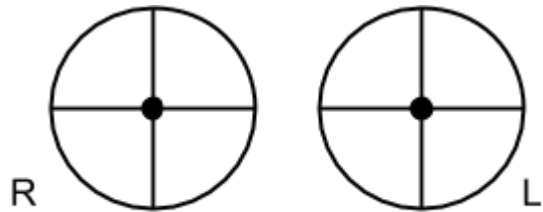
Patient Name _____ Date of Birth _____

Patient Phone _____ Email _____

Referring Physician Name _____

Referring Physician Signature _____ Date _____

Patient History:



- Screening Digital Mammogram
 - Change to diagnostic, as needed
 - Screening breast ultrasound, if dense breast tissue
- Screening Bilateral Breast Ultrasound for Dense Tissue
- Diagnostic Digital Mammogram Right Left Bilateral
- Diagnostic Breast Ultrasound Right Left Bilateral
- Ultrasound Guided Core Biopsy Right Left Bilateral
- Ultrasound Guided Cyst Aspiration Right Left Bilateral