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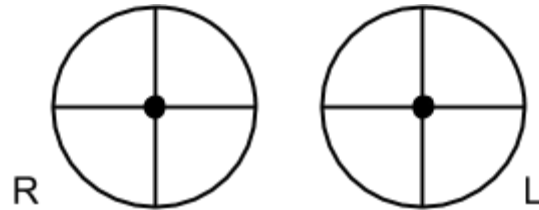
Patient Name _____ Date of Birth _____

Patient Phone (H) _____ (C) _____

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