

*****CONFIDENTIAL*** Patient Referral Form for Penn Medicine Breast Health Initiative**
Fax completed form to Emily Verderame at (215) 829-8454 with patient's script (if available)
Questions? Please call Emily Verderame at (215) 454-3217



Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Phone: _____ **Alternative Phone:** _____

Date of Birth: _____ (MM/DD/YYYY) **Social Security number (if known):** _____ - _____ - _____

Email: _____ **Preferred language:** _____

Have you ever had a mammogram? : YES ___ NO ___

Date of last mammogram: _____

Location of last mammogram: _____

Do you have breast implants? : YES ___ NO ___

Do you currently have any new lumps, mass, pain or nipple discharge in your breasts? : YES ___ NO ___

Which breast? Right ___ Left ___ Both ___ Please describe issue: _____

Are you currently pregnant? : YES ___ NO ___

Are you currently breastfeeding? : YES ___ NO ___

Have you ever had breast cancer? : YES ___ NO ___

Have you had a gynecological exam in the last 5 years? : YES ___ NO ___

What appointment date and time do you prefer? : _____

(Appointments available Monday through Friday, 7:30 am to 3:30 pm)

Which location do you prefer? :

- | | |
|---|---|
| <input type="checkbox"/> Pennsylvania Hospital
800 Spruce Street
Philadelphia, PA 19107
(Corner of 8 th St. and Spruce St.) | <input type="checkbox"/> Perelman Center for Advanced Medicine – Ground Floor
3400 Civic Center Blvd
Philadelphia, PA 19014
(Near 34 th St. and Spruce St., across from CHOP) |
| <input type="checkbox"/> Penn Medicine Radnor
250 King of Prussia Road
Radnor, PA 19087 | <input type="checkbox"/> Penn Medicine Valley Forge
1001 Chesterbrook Blvd., Suite 100
Berwyn, PA 19312 |
| <input type="checkbox"/> Penn Medicine Bucks County
777 Township Line
Yardley, PA 19067 | |

Do you currently have health insurance? : YES ___ NO ___

Referring for (choose one):

- Routine Screening Mammogram
 Diagnostic Mammogram: Breast, Left ___ Right ___ Both ___

Name of Primary Care Provider/Referring Provider: _____ **Phone:** _____ **Provider**

Location: _____ (Street, City, State, Zip)