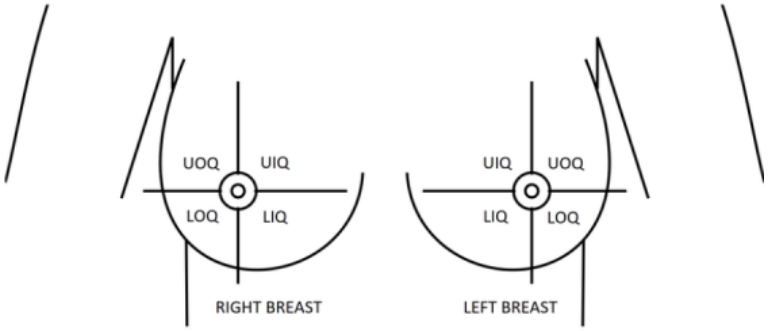
Fax: 425.642.3662
Phone: 425.523.1212

Thrive
LACTATION & WELLNESS

THERAPEUTIC BREAST ULTRASOUND REFERRAL

Patient Name:	Email:		
Phone:	DOB:		
Address:	City:	State:	Zip:
Provider Name:		NPI:	
Practice/Office Name:			
Phone:	Fax:		

CPT	**Diagnosis**
☐ **97035 (Ultrasound Therapy)**	☐ **O92.79 (Other disorders of lactation)** ☐ **O92.2 (Breast Lump)**



Notes:

Provider Signature:_____ Date:_____

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