



The Thermogram Center

Thermal Imaging of the Breast & Body

Breast Health Education Group

Better Breast Health – for Life![™]

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www.ThermogramCenter.com

www.BetterBreastHealthforLife.com

HEALTH CARE PROVIDER (HCP) REFERRAL FORM

Please Write Legibly And Firmly.

If completed by HCP: please fax this referral form to 303-664-1146.

If completed by patient: please bring with you to your RATI appointment.

Patient Name: _____

Patient Day-Time Phone Number: _____

Referring Healthcare Provider Info: _____ **Date:** _____

Name: _____

Office Number: _____ **Contact Name:** _____

Report mailing address: _____

And/or e-mail address for reports: _____

Reason for Imaging: _____

and/or Diagnostic Code: _____

The following is to be completed by HCP only. (Patients: leave blank)

Imaging Requested: (check all that apply)

- Breast Series Other: _____
- Abdomen, Back & Face Series Stress Challenge (for RSD, CRPS, Pain Study)
- Face Series
- Upper Body (face, neck, chest, back, upper extremities)
- Lower Body (back, abdomen, buttocks, lower extremities)