SAMPLE LETTER FOR BREAST REDUCTION

Date:

Re:

To Whom It May Concern,

Please be advised MS _____ has been suffering from long term back pain/discomfort. Her pain has not been relieved with the use of anti-inflammatory medications and muscle relaxers. In addition she has not improved with physical therapy/and/or chiropractic treatment. In addition, she has suffered from recurrent fungal rashes that have been unresponsive to over the counter and prescription antifungal creams.

In summary Ms _____ back pain and rashes have not been relieved from these therapeutic measures and it is my opinion that it is all related to her large breast size. She would greatly benefit from a breast reduction.

Note: some of these sentences are only appropriate for those that have received these treatments and should be discarded if the above mentioned treatments were not performed.

Breast Reduction Surgery Preliminary Requirements

- 6 month documentations of all conservative measures that have been taken to relieve pain/discomfort
- Rashes: treatment with either prescription and over the counter medication/creams.
- Back pain/neck pain: seen by chiropractor or physical therapy use of prescription or over the counter medication.
- Must have mammogram if over 40 years of age and been within one year.
- Must obtain support letter from primary doctor and other providers.