

BASELINE FORM

Baseline			
Unique Medical Identifier Number (Autogenerated)	Name of Plastic Surgeon	First	Last
Patient Identifier (Optional)	Patient Date of Birth (MM/DD/YYYY) _____/_____/_____		
Patient gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
Area(s) treated <input type="checkbox"/> Breast <input type="checkbox"/> Face <input type="checkbox"/> Buttocks <input type="checkbox"/> Other, please specify _____			
Fat Grafting Technique			
Date of procedure (MM/DD/YYYY)	_____/_____/_____		
Fat Processing Technique (Check all that apply)	<input type="checkbox"/> Telfa roll <input type="checkbox"/> Centrifuge <input type="checkbox"/> Decanting <input type="checkbox"/> Filter/Strain <input type="checkbox"/> Wash <input type="checkbox"/> Revolve <input type="checkbox"/> Puregraft <input type="checkbox"/> Other, please specify _____		
Was enzymatic digestion used to isolate autologous stem cells from the raw fat?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes to Face, Answer the following			
Indication for the fat grafting procedure?	<input type="checkbox"/> Reconstructive <input type="checkbox"/> Aesthetic		
Total volume injected (ml)			
If Yes to Buttocks, Answer the following			
Indication for the fat grafting procedure?	<input type="checkbox"/> Reconstructive <input type="checkbox"/> Aesthetic		
Total volume injected (ml)	<input type="checkbox"/> Left (ml) _____ <input type="checkbox"/> Right (ml) _____		
If Yes to Breast, Answer the following			
Location of graft	<input type="checkbox"/> Left Breast <input type="checkbox"/> Right Breast		
Total volume injected (ml)	<input type="checkbox"/> Left (ml) _____ <input type="checkbox"/> Right (ml) _____		
Has the patient had any cancer diagnosis?	<input type="checkbox"/> No <input type="checkbox"/> In the last 3 years <input type="checkbox"/> More than 3 years ago		
Location of cancer	<input type="checkbox"/> Left Breast <input type="checkbox"/> Right Breast <input type="checkbox"/> Bilateral		
Surgical treatment?	<input type="checkbox"/> Mastectomy <input type="checkbox"/> Partial mastectomy <input type="checkbox"/> None		
Indication for the fat grafting procedure?	<input type="checkbox"/> Reconstructive	<input type="checkbox"/> Contour Deformity <input type="checkbox"/> Augmentation of autologous tissue <input type="checkbox"/> Fat graft for primary reconstruction <input type="checkbox"/> Contralateral symmetry procedure <input type="checkbox"/> Congenital deformity	
	<input type="checkbox"/> Aesthetic	<input type="checkbox"/> Augmentation <input type="checkbox"/> Augmentation to replace implant <input type="checkbox"/> Mastopexy (without implant) <input type="checkbox"/> Contour Deformity	
If Yes to Other, Answer the following			
Indication for the fat grafting procedure?	<input type="checkbox"/> Reconstructive <input type="checkbox"/> Aesthetic		
Total volume injected (ml)			

FOLLOW-UP FORM

Follow-Up (if Yes to Face)	
Date of follow up visit (MM/DD/YYYY)	_____ / _____ / _____
Has the patient had any complications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please select all that apply:	<input type="checkbox"/> Infection <input type="checkbox"/> Palpable mass <input type="checkbox"/> Fat necrosis <input type="checkbox"/> Skin necrosis or tissue loss <input type="checkbox"/> Oil cyst <input type="checkbox"/> Blindness <input type="checkbox"/> Stroke <input type="checkbox"/> Donor site issues <input type="checkbox"/> Other, please specify
Follow-Up (if Yes to Buttocks)	
Date of follow up visit (MM/DD/YYYY)	_____ / _____ / _____
Has the patient had any complications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please select all that apply:	<input type="checkbox"/> Infection <input type="checkbox"/> Palpable mass <input type="checkbox"/> Fat necrosis <input type="checkbox"/> Oil cyst <input type="checkbox"/> Fat embolism with morbidity Explain: <input type="checkbox"/> Fat embolism with mortality Explain: <input type="checkbox"/> Donor site issues <input type="checkbox"/> Other, please specify
Follow-Up (if Yes to Breast)	
Date of follow up visit (MM/DD/YYYY)	_____ / _____ / _____
Has the patient had any complications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please select all that apply:	<input type="checkbox"/> Infection <input type="checkbox"/> Palpable mass <input type="checkbox"/> Fat necrosis <input type="checkbox"/> Oil cyst <input type="checkbox"/> Donor site issues <input type="checkbox"/> Other, please specify
Has the patient had a new cancer diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please select all that apply:	<input type="checkbox"/> Ipsilateral <input type="checkbox"/> Contralateral <input type="checkbox"/> Bilateral <input type="checkbox"/> Distant metastasis
Has the patient had a cancer recurrence?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please select all that apply:	<input type="checkbox"/> Ipsilateral <input type="checkbox"/> Contralateral <input type="checkbox"/> Bilateral <input type="checkbox"/> Distant metastasis
Was any imaging (MRI/Mammography/USG) or Biopsy performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please select all that apply:	<input type="checkbox"/> Ipsilateral <input type="checkbox"/> Contralateral <input type="checkbox"/> Bilateral
Follow-Up (if Other)	
Date of follow up visit (MM/DD/YYYY)	_____ / _____ / _____
Has the patient had any complications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please select all that apply:	<input type="checkbox"/> Infection <input type="checkbox"/> Palpable mass <input type="checkbox"/> Fat necrosis <input type="checkbox"/> Oil cyst <input type="checkbox"/> Donor site issues <input type="checkbox"/> Other, please specify