GRAFT

THE PLASTIC SURGERY FOUNDATION ™

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

GRAFT

THE PLASTIC SURGERY FOUNDATION ™

FOLLOW-UP FORM

Follow-Up (if Yes to Face)	
Date of follow up visit (MM/DD/YYYY)	_____/_____ / _____
Has the patient had any complications?	☐ **Yes** ☐ **No**
If Yes, please select all that apply:	☐ Infection ☐ Palpable mass ☐ Fat necrosis ☐ Oil cyst ☐ Donor site issues ☐ Other, please specify
Follow-Up (if Yes to Buttocks)	
Date of follow up visit (MM/DD/YYYY)	_____/_____ / _____
Has the patient had any complications?	☐ **Yes** ☐ **No**
If Yes, please select all that apply:	☐ Infection ☐ Palpable mass ☐ Fat necrosis ☐ Oil cyst ☐ Donor site issues ☐ Other, please specify
Follow-Up (if Yes to Breast)	
Date of follow up visit (MM/DD/YYYY)	_____/_____ / _____
Has the patient had any complications?	☐ **Yes** ☐ **No**
If Yes, please select all that apply:	☐ Infection ☐ Palpable mass ☐ Fat necrosis ☐ Oil cyst ☐ Donor site issues ☐ Other, please specify
Has the patient had a new cancer diagnosis?	☐ **Yes** ☐ **No**
If Yes, please select all that apply:	☐ Ispilateral ☐ Contralateral ☐ Bilateral ☐ Distant metastasis
Has the patient had a cancer recurrence?	☐ **Yes** ☐ **No**
If Yes, please select all that apply:	☐ Ispilateral ☐ Contralateral ☐ Bilateral ☐ Distant metastasis
Was any imaging (MRI/Mammography/USG) or Biopsy performed?	☐ **Yes** ☐ **No**
If Yes, please select all that apply:	☐ Ispilateral ☐ Contralateral ☐ Bilateral
Follow-Up (if Other)	
Date of follow up visit (MM/DD/YYYY)	_____/_____ / _____
Has the patient had any complications?	☐ **Yes** ☐ **No**
If yes, please select all that apply:	☐ Infection ☐ Palpable mass ☐ Fat necrosis ☐ Oil cyst ☐ Donor site issues ☐ Other, please specify