GRAFT

BASELINE FORM

THE PLASTIC SURGERY FOUNDATION ™

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 (Please select 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**		
Was the fat grafting performed for treating radiation or burns?	☐ **Yes** ☐ **No** ☐ **Unknown** **If yes,** ☐ **Radiation** ☐ **Burns**		
Is this a primary or subsequent fat grafting procedure?	☐ **Primary** ☐ **Secondary** ☐ **Tertiary** ☐ **Other, please specify** _____		
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)** _____		
Cannula size for harvest (Diameter, select one):	☐ **1-2.5mm** ☐ **2.6-4mm** ☐ **> or equal to 4mm**		
Fat transfer tool/device (Please select all that apply):	☐ **Blunt Needle** ☐ **Sharp Needle** ☐ **Cannula** ☐ **Syringe** ☐ **Infusion pump** ☐ **Infusion pump with vibrating cannula**		
	Cannula length ☐ **<9cm** ☐ **9cm** ☐ **15cm** ☐ **20cm** ☐ **>20cm** *If yes to Cannula*		
	Cannula diameter ☐ **Less than 2mm** ☐ **Greater than or equal to 2mm but less than 3mm** ☐ **Greater than or equal to 3mm but less than 4mm** *If yes to Cannula* ☐ **4mm or larger**		
	Syringe volume ☐ **<or equal to 1-3cc** ☐ **5-10cc** ☐ **20-35cc** *If yes to Syringe* ☐ **60cc** ☐ **Other**		
	☐ **Other tool/device please specify** _____		
In what planes did you attempt to inject fat (Please select all that apply)	☐ **Subcutaneous** ☐ **Intramuscular (Within the gluteus maximus muscle)** ☐ **Sub-muscular (deep to the gluteus)**		
If Yes to Breast, Answer the following			
Location of graft	☐ **Left Breast** ☐ **Right Breast** ☐ **Bilateral**		
Total volume injected (ml)	☐ **Left (ml)** _____ ☐ **Right (ml)** _____		
Has the patient had any breast cancer diagnosis?	☐ **No** ☐ **In the last 3 years** ☐ **More than 3 years ago**		
Location of cancer	☐ **Left Breast** ☐ **Right Breast** ☐ **Bilateral**		

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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)		

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FOLLOW-UP FORM

Complications reported should be related to medical reason only and not for suboptimal cosmetic results (i.e. contour irregularity).

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** ☐ *Recipient Site* ☐ *Donor Site* ☐ **Palpable mass** ☐ *Recipient Site* ☐ **Fat necrosis** ☐ *Recipient Site* ☐ **Skin necrosis or tissue loss** ☐ *Recipient Site* ☐ *Donor Site* ☐ **Oil cyst** ☐ *Recipient Site* ☐ *Donor Site* ☐ **Hematoma** ☐ *Recipient Site* ☐ *Donor Site* ☐ **Seroma** ☐ *Recipient Site* ☐ *Donor Site* ☐ **Blindness** ☐ **Stroke** ☐ **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** ☐ *Recipient Site* ☐ *Donor Site* ☐ **Palpable mass** ☐ *Recipient Site* ☐ **Fat necrosis** ☐ *Recipient Site* ☐ **Wound Healing Issues** (as a complication of fat grafting) ☐ *Recipient Site* ☐ *Donor Site* ☐ **Oil cyst** ☐ *Recipient Site* ☐ *Donor Site* ☐ **Gluteal Explant** (as a complication of fat grafting) ☐ **Fat embolism with morbidity** *If Yes, Explain:* ☐ **Fat embolism with mortality** *If Yes, Explain:* ☐ **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**

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FOLLOW-UP FORM

Complications reported should be related to medical reason only and not for suboptimal cosmetic results (i.e. contour irregularity).

Follow-Up (if Yes to Breast)	
If Yes, please select all that apply:	☐ **Infection/Cellulitis** ☐ *Recipient Site* ☐ *Donor Site* ☐ **Palpable mass** ☐ *Recipient Site* ☐ **Fat necrosis** ☐ *Recipient Site* ☐ **Wound Healing Issues** (as a complication of fat grafting) ☐ *Recipient Site* ☐ *Donor Site* ☐ **Oil cyst** ☐ *Recipient Site* ☐ *Donor Site* ☐ **Seroma** ☐ *Recipient Site* ☐ *Donor Site* ☐ **Explant** (as a complication of fat grafting) ☐ **Other,** *please specify*
Has the patient had a new cancer diagnosis?	☐ **Yes** ☐ **No**
If Yes, please select all that apply:	☐ Ipsilateral ☐ Contralateral ☐ Bilateral ☐ Distant metastasis
Has the patient had a cancer recurrence?	☐ **Yes** ☐ **No**
If Yes, please select all that apply:	☐ Ipsilateral ☐ Contralateral ☐ Bilateral ☐ Distant metastasis
Was any imaging (MRI/Mammography/USG) or Biopsy performed?	☐ **Yes** ☐ **No**
If Yes, please select all that apply:	☐ Ipsilateral ☐ Contralateral ☐ Bilateral

Follow-Up (if Other)	
Date of follow up visit (MM/DD/YYYY)	_____/_____ / _____
Has the patient had any complications?	☐ **Yes** ☐ **No**
	☐ Infection ☐ Palpable mass ☐ Fat necrosis ☐ Oil cyst ☐ Donor site tissues ☐ Other, please specify