BREASTORATION

Physician Breast Reconstruction Verification Form

Patient Information

Full Name: _____

Date of Birth: _____

Physician/Provider Information

Reconstructive Surgeon Name: _____

Practice Name: _____

Address: _____

City: _____ ZIP Code: _____

E-mail: _____ Phone: _____

Louisiana Surgical Facility/Hospital: _____

Reconstructive Verification

Patient qualifies for breast reconstruction due to:

- ☐ Breast cancer diagnosis requiring mastectomy/partial mastectomy
- ☐ Documented increased breast cancer risk requiring prophylactic mastectomy

Mastectomy Date (if applicable): _____

Reconstruction Status:

- ☐ Immediate reconstruction with mastectomy
- ☐ Delayed reconstruction after prior mastectomy
- ☐ Active staged reconstruction
- ☐ Revision/completion procedure
- ☐ Correction of failed or unsuccessful reconstruction

Type of Reconstruction:

- ☐ DIEP flap/autologous tissue reconstruction
- ☐ Other flap reconstruction: _____
- ☐ Tissue expander placement
- ☐ Implant reconstruction
- ☐ Implant exchange
- ☐ Revision procedure
- ☐ Fat grafting
- ☐ Nipple/areola reconstruction
- ☐ Correction of failed reconstruction
- ☐ Other: _____

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Reconstruction Date: _____

Estimated Recovery Period:

- ☐ Less than 2 weeks
- ☐ 2–6 weeks
- ☐ Greater than 6 weeks

Expected return to normal activities/work _____

Complications / Extraordinary Circumstances

Does the patient have reconstruction-related complications or circumstances expected to prolong recovery?

- ☐ Yes
- ☐ No

If yes, explain.

_____

_____

Physician Certification

I certify that the information provided accurately reflects the patient's breast reconstruction procedure and anticipated recovery needs.

Physician's Signature: _____

Printed Name: _____

Date: _____