AUSTRALIAN BREAST DEVICE REGISTRY FORM

AUSTRALIAN Breast Device REGISTRY

MONASH University Medicine, Nursing and Health Sciences

Australian Society of Plastic Surgeons

Breast Surgeons of Australia & New Zealand

AFFIX **PATIENT** STICKER or complete details below:

Patient UR # :

Medicare # :

Surname : _____

First name: _____ Middle Name: _____

Birth Date: / / (dd/mm/yyyy)

Address : _____

_____ State: P/code:

Telephone : - Home: Business:

Mobile :

Email : _____

OPERATION DATE: (dd/mm/yy) / /

SITE DETAILS:

Site Name: _____

Suburb: _____ State: _____

Surgeon name: _____

Is this patient a medical tourist to Australia? Yes No

RETURN FORM:

Australian Breast Device Registry,
Monash University, DEPM,
553 St Kilda Road, Melbourne 3004
email: abdr@monash.edu **fax:** (03) 9903 0277
contact phone: (03) 9903 0205

AFFIX **RIGHT DEVICE** STICKER

[COMPLETE IF NO DEVICE STICKER]

Manufacturer: _____

Distributor: _____

Reference no: _____

Serial no: _____

AFFIX **LEFT DEVICE** STICKER

[COMPLETE IF NO DEVICE STICKER]

Manufacturer: _____

Distributor: _____

Reference no: _____

Serial no: _____

AFFIX **MESH/DERMAL SHEET** STICKER

[COMPLETE IF NO DEVICE STICKER]

MESH/DERMAL SHEET: Yes No

Manufacturer: _____
Reference no: _____
Serial no: _____

AFFIX **MESH/DERMAL SHEET** STICKER

[COMPLETE IF NO DEVICE STICKER]

MESH/DERMAL SHEET: Yes No

Manufacturer: _____
Reference no: _____
Serial no: _____

PATIENT HISTORY:

RIGHT BREAST

Tick if Same Bilateral

BREAST **LEFT**

Category of operation

- Cosmetic augmentation
- Reconstruction - post cancer
- Reconstruction - benign / prophylactic
- Congenital deformity

Operation type

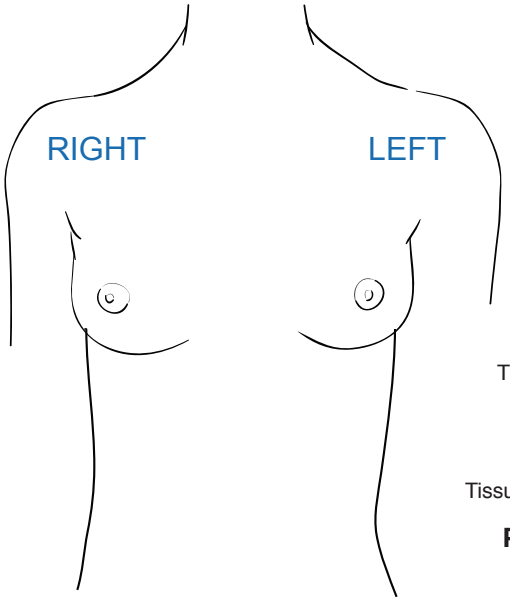
Initial (new device)

- Tissue Expander insertion
- First Implant insertion
- Tissue Expander removal & Implant insertion

Revision of in situ device

- Implant revision, removal or replacement
- Tissue Expander revision, removal, replacement

Previous Radiotherapy Yes No



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Revision of in situ device

- Implant revision, removal or replacement
- Tissue Expander revision, removal, replacement

Previous Radiotherapy Yes No

PLEASE COMPLETE OVER PAGE

ELEMENTS OF OPERATION

RIGHT BREAST

Tick if Same Bilateral

Incision site
- ☐ Axillary
- ☐ Areolar
- ☐ Infra-mammary
- ☐ Previous mastectomy scar
- ☐ Mastopexy/reduction wound
- ☐ .....

Plane
- ☐ Sub-glandular / Sub-fascial
- ☐ Sub-pectoral
- ☐ Sub-flap

Concurrent Mastectomy..... ☐ Yes ☐ No
Axillary surgery incl. sentinel node biopsy ..... ☐ Yes ☐ No
Concurrent Mastopexy / Reduction ..... ☐ Yes ☐ No
Concurrent Flap cover ..... ☐ Yes ☐ No
Previous Mastopexy/Reduction ..... ☐ Yes ☐ No

Fat grafting ☐ Yes Volume.....mLs ☐ No

IF TISSUE EXPANDER, Intra Operative fill volume: .....mLs

BREAST LEFT

Plane
- Subglandular / Sub-fascial ☐
- Sub-pectoral ☐
- Sub-flap ☐

Incision site
- Axillary ☐
- Areolar ☐
- Infra-mammary ☐
- Previous mastectomy scar ☐
- Mastopexy/reduction wound ☐
- ..... ☐

☐ Yes ☐ No ..... **Concurrent Mastectomy**
☐ Yes ☐ No ..... **Axillary surgery incl. sentinel node biopsy**
☐ Yes ☐ No ..... **Concurrent Mastopexy / Reduction**
☐ Yes ☐ No ..... **Concurrent Flap cover**
☐ Yes ☐ No ..... **Previous Mastopexy/Reduction**

Fat grafting ☐ Yes Volume.....mLs ☐ No

IF TISSUE EXPANDER, Intra Operative fill volume: .....mLs

INTRAOPERATIVE TECHNIQUES

☐ Intra-op prophylactic antibiotic ☐ Antibiotic dipping solution ☐ Post-op antibiotic
☐ Glove change for insertion ☐ Sleeve/funnel ☐ Antiseptic rinse .....

RIGHT BREAST

Tick if Same Bilateral

- ☐ Nipple absent
- ☐ Nipple sparing
- ☐ Occlusive nipple shield
- ☐ Drain used

BREAST LEFT

- Occlusive nipple shield ☐
- Drain used ☐
- Nipple absent ☐
- Nipple sparing ☐

FOR REVISION SURGERY ONLY

RIGHT BREAST

Tick if Same Bilateral

Revision Type:
☐ Replacement ☐ Reposition existing implant ☐ Explant only

Capsulectomy ..... ☐ Full ☐ Partial ☐ None

Neo pocket formation ... ☐ Yes ☐ No ☐ Subglandular ☐ Submuscular

Explanted device: Ref.No. / Manufacturer: .....
Shell: ..... Fill: ..... Vol: ..... Date of Insert: ...../...../.....
☐ Round ☐ Anatomical ☐ Indeterminate

Reason for Revision

Tick if Same Bilateral

☐ Complication ☐ Asymptomatic ☐ Patient Preference

Is the operation removing an implant inserted overseas ☐ Yes ☐ No

Details : .....

Device rupture?

Tick if Same Bilateral

☐ Yes, reason for revision ☐ Yes, found incidentally ☐ No

If yes, please indicate whether silicone extravasation was found:

☐ Intracapsular ☐ Extracapsular ☐ Distant

BREAST LEFT

Revision Type:
Replacement ☐ Reposition existing implant ☐ Explant only ☐

Capsulectomy ..... Full ☐ Partial ☐ None ☐

Neo pocket formation ... Yes ☐ No ☐ Subglandular ☐ Submuscular ☐

Explanted device: Ref.No. / Manufacturer: .....
Shell: ..... Fill: ..... Vol: ..... Date of Insert: ...../...../.....
Round ☐ Anatomical ☐ Indeterminate ☐

Reason for Revision

Complication ☐ Asymptomatic ☐ Patient Preference ☐

Is the operation removing an implant inserted overseas Yes ☐ No ☐

Details : .....

Device rupture?

Yes, reason for revision ☐ Yes, found incidentally ☐ No ☐

If yes, please indicate whether silicone extravasation was found:

Intracapsular ☐ Extracapsular ☐ Distant ☐

Yes, reason for revision	Yes, found incidentally	No	Issue identified at revision	No	Yes, found incidentally	Yes, reason for revision
☐	☐	☐	Device deflation	☐	☐	☐
☐	☐	☐	Capsular contracture	☐	☐	☐
☐	☐	☐	Device malposition	☐	☐	☐
☐	☐	☐	Skin scarring problems	☐	☐	☐
☐	☐	☐	Deep wound infection	☐	☐	☐
☐	☐	☐	Seroma/Haematoma	☐	☐	☐
☐	☐	☐	Breast cancer	☐	☐	☐
☐	☐	☐	Anaplastic Large Cell Lymphoma	☐	☐	☐