

63559

BREAST LYMPHATIC MAPPING DATABASE

Surgical History Form (Page 1 of 2)

Patient Study ID

Physician ID

Patient History & Physical Exam

Date: / /

Side of primary: right left

Location of primary: UOQ UIQ LOQ LIQ Central

Palpable lesion: yes no

Mammographic abnormality: none mass architectural distortion calcification (Choose all that apply)

Breast Biopsy

Date: / /

Type of biopsy: FNA excisional incisional stereotactic core biopsy

Lymphoscintigraphy

Date: / /

Radioactive tracer: unfiltered Tc99 sulfur colloid filtered Tc99 sulfur colloid

Other tracer:

Injection by: palpable tumor ultrasound, post exc. biopsy mammogram, needle loc around biopsy cavity **Dose (uCi):**

Axillary drainage: yes no

Internal mammary drainage: yes no

Other drainage site:

Sentinel Node Biopsy

Date: / /

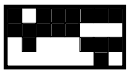
Timing relative to breast surgery: before after **Blue dye injected (cc):** .

Number of nodes harvested: **SLNs:** **Non-SLNs:**

Completion node dissection done? yes no

Reason for CLND: Node Grossly Positive Lymphatic Mapping Failed Phase I patient

Axillary drain used? yes no **Number of days:**



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Surgical History Form (Page 2 of 2)

Breast Surgery

Date: / /

Type of surgery: lumpectomy modified radical mastectomy

Other surgery:

Anesthesia: general local MAC

Other anesthesia:

Location performed in: OR OPTR

Other location:

Other Operative Data

Total operative time (mins.):

Length of hospital stay (hours):

Intraoperative Complications

Complications: none cardiac event respiratory failure death
 dye reaction pneumothorax CPR

Other Complications: