Doc 10

FOLLOW UP SLIP

FOLLOW UP DATE ..... / ..... / .....

Please fully complete this form and give it to your sales representative or send it to:

P.I.P. 337, Avenue de Bruxelles - 83507 LA SEYNE-SUR-MER Cedex - FRANCE

Operation date: ..... / ..... / .....

Follow up at: _____ **months**

Surgeon's identification (or stamp)

Name :

Address :

Tel. :

F[illegible]

Patient's identification

Name (3 letters)

Age

CLINICAL EXAM	LEFT	RIGHT
Capsule contraction following BAKER classification I to IV		
Hematoma (location)		
Liquid build up (location)		
Pneumothorax		
Infection		
Implant displacement / extrusion		
Increase or decrease of nipple sensibility		
Asymmetry		
Pain		
[illegible]pling problem		
Inflammation / Eruption		
Necrosis		
Adenopathy		
Folds		
Implant calcification		
Deflation / Rupture (to precise)		
Others		

CONSEQUENCES and TREATMENT:

POST-OP CONCLUSIONS:

CONCLUSIONS:

DATE & SURGEON SIGNATURE:

SQ1/15 FOR 700 - A

[redacted]