201 Evans Rd; Suite 319
New Orleans, LA 70123
(504) 733-5539, **WITHIN** Metro New Orleans
FAX: (504) 733-0252

A UNITED WAY PARTNER

Breast Reconstruction Information Sheet ***Date:*** _____

Breast Reconstruction is needed as a result of a breast cancer diagnosis and mastectomy Per the requirements of CALA/Breastoration, this letter represents that I am the breast reconstruction surgeon for _____ (hereafter "Patient"). As the Surgeon, I certify that the patient is in need of reconstructive surgery of the **RIGHT/ LEFT/ BOTH [Circle One]** Breast(s) as a result of the mastectomy.

_____ _____

Signature of surgeon preforming the reconstruction Printed Name of surgeon preforming the reconstruction

Mastectomy Information Check all that apply

☐ The Patient had or will have a Unilateral mastectomy on the **RIGHT / LEFT [Circle One]** breast on _____ **[Date].**

☐ The Patient had or will have a Bilateral mastectomy on _____ **[Date].**

Breast Reconstruction Information

☐ The Patient had or will have unilateral reconstruction on the **RIGHT / LEFT [Circle One]** breast on _____ **[Date].**

☐ The Patient had or will have bilateral reconstruction **[Circle One]** on _____ **[Date].**

☐ The Patient had or will have unilateral reconstruction on a single breast with a breast lift, breast reduction or
breast augmentation of the unaffected breast on _____ **[Date].**

☐ The Patient had a single mastectomy in the past but will have a bilateral mastectomy and reconstruction on both breasts on _____ **[Date].**

If you have any questions regarding this application, please call 504-733-5539 or email tammy@cagno.org

Sincerely, Tammy L Swindle