Patient Name: _____ Hospital ID #: _____ OR: (Sticker below)

UNIVERSITY OF MISSOURI-COLUMBIA
BRACHYTHERAPY WRITTEN DIRECTIVE WORKSHEET

Patient Sticker

Patient name: _____
Hospital ID#: _____

Diagnosis: _____

BRACHYTHERAPY PRESCRIPTION (Written Directive)

Radionuclide: _____ Form: _____ Administration: Permanent implant only

Treatment site: _____

Desired Dose: _____ # Sources: _____

Source Strengths: □ _____ mCi/seed (apparent activity)
□ _____ U/seed

U Total: _____

_____ _____
(Authorized User Physician's Signature) Date

Brachytherapy Treatment Plan

Calculated by: _____ Date _____

Checked by: _____ Date _____

Pre-Implant Verification of Sources (compare to prescription/written directive)

Radioisotope: _____ #Sources_____

Source ID & Activity: □ Visual □ Dose Cal. □ Exposure Rate

Initialed: _____ Date: _____

If you do not understand the above instructions or there are any discrepancies, see the Authorized User Physician and/or the RSO for Clarification.

Patient Identification Check

The Patient was identified by two or more of the following means:

□ Time Out □ Name □ Birth Date □ Address □ Social Security # □ Signature □ ID Bracelet □ ID Card

□ Medical Insurance Card □ Photo in Patient's Planning Chart □ Other_____

Date: _____ Signature: _____
(Signature)

RETAIN THIS RECORD FOR 3 YEARS AFTER ADMINISTRATION, PER 10CFR 35.2040

Patient Name: _____ Hospital ID #: OR: (Sticker below)

Patient Sticker

Patient name: _____
Hospital ID#: _____

Record of Brachytherapy Dose Administration

Date: _____ Physician Signature: _____

Instructions: Authorized User/Physician shall initial all changes

Treatment Site: ☐ No Change ☐ Changed to: _____ Physician (AU):_____

Radionuclide: ☐ No Change
☐ Changed to: _____
Physician (AU) Initials:_____

Sources Implanted: ☐ No Change
☐ Changed to: _____
Physician (AU) Initials:_____

Dose: ☐ No Change
☐ New Dose: _____
Physician (AU) Initials:_____

Total source strength: ☐ No Change
☐ New total source strength_____
Physician (AU) Initials:_____

Comments: _____

All revisions to prescription/written directive must be signed and dated by the Authorized User as per the Procedures for Written Directives.

Patient Release Verification - Permanent implants only

Release Method – Select the method by which the patient will be released: by dose rate at one meter from the patient, or other criteria.

Radionuclide	☐ Dose rate at one meter from patient at, or below which the patient may be released:		☐ Other Criteria
			(see attached)
I-125 implant	≤ 1 mR/hr at 1 meter	**OR**	
Pd-103 implant	≤ 3 mR/hr at 1 meter		
Ir-192 implant	≤ 0.8 mR/hr at 1 meter		
Cs-131 implant	< 6 mR/hr at 1 meter		
	AND		**AND**
All radionuclides	☐ Verify written instructions were provided		☐ Verify written instructions were provided

Table U.1 or Appendix U: Activities and Dose Rates for Authorizing Patient Release: NUREG 1556, Volume 9

Dose Rate @ 1m from the patient: _____mR/h

Does patient meet release criteria? ☐ Yes ☐ No

Room Survey: Patient/implant area: _____mR/h Linens: _____mR/h Trash: _____mR/h

Room # _____ and all items are cleared for normal handling: ☐ Yes ☐ No

Survey Date: _____ Performed by: _____

The patient may be discharged from the hospital in accordance with orders from the referring physician. The patient room and any items collected in the room including linens and trash are released for normal handling.

Survey instrument

Instrument Manf.: _____ MN: _____ SN: _____ Calibration date: _____

Background: _____ mR/h Battery Check passed? ☐ Yes ☐ No

Check Source: _____ mR/h Check source pass? ☐ Yes ☐ No

RETAIN THIS RECORD FOR 3 YEARS AFTER ADMINISTRATION, PER 10CFR 35.2040