Patient Name: _____ Hospital ID #: _____

UNIVERSITY OF MISSOURI-COLUMBIA
BRACHYTHERAPY WRITTEN DIRECTIVE WORKSHEET

Patient Sticker

Patient name: _____
Hospital ID#: _____

Diagnosis: _____

BRACHYTHERAPY PRESCRIPTION (Written Directive)

Radionuclide: _____ Form: _____ Administration: Temporary implant only

Treatment site: _____

Desired Dose: _____ # Sources: _____ Dose Rate: _____

Source Strengths: Loading Sequence:

_____ _____
Authorized User Physician's Signature) Date/Time

Brachytherapy Treatment Plan

Calculated by: _____ Date/Time _____

Verified by: _____ Date/Time _____

Checked by: _____ Date/Time _____

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

Radioisotope: _____ #Sources_____

Source ID & Activity: Visual Dose Cal. Exposure Rate

Initialed: _____ Date: _____ Time: _____

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 one or more of the following means:

Name Birth Date Address Social Security # Signature ID Bracelet ID Card

Medical Insurance Card Photo in Patient's Planning Chart Other_____

Date/Time: _____ _____

RETAIN THIS RECORD FOR 3 YEARS AFTER ADMINISTRATION, PER 10CFR 35 2040

Patient Name: _____ Hospital ID #: _____

Patient Sticker

Patient name: _____
Hospital ID#: _____

Record of Brachytherapy Dose Administration

Date: _____ Start Time: _____ Physician Signature: _____

Instructions: 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.

Record of Removal of Sources from Patient - Temporary implants only

Date: _____ Removal Time: _____ Total # Sources Removed: _____

Physician Signature: _____

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

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: _____ Survey Time: _____ 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