E.12

Written Directive

Accelerated Partial Breast Irradiation

Patient Name: _____

Medical Record Number: _____ Date of Birth: _____

Treatment Site: Breast Left ☐ Right ☐

Radiation Oncologist: _____

Total Prescribed Dose (cGy): _____ Prescription Point: _____

Prescribed Dose per Fraction (cGy): _____ No. of Fractions: _____

Radionuclide: **Iridium-192** Activity as of Plan date (Ci): _____

Applicator Type: _____

No. of Channels: _____ No. of Dwell Positions: _____

Balloon Info.

Type: _____ Fill Volume (cc): _____

Length (mm): _____ Width (mm): _____

Minimal Distance to Skin (mm): _____

Special Instructions: _____

Radiation Oncologist Signature: _____ Date: _____

Comments: ***Treat BID, six hours apart.***

Written Directive – GYN: Cylinder

Patient Name: _____

Medical Record Number: _____ Date of Birth: _____

Treatment Site: _____

Radiation Oncologist: _____

Plan ID: _____

Total Prescribed Dose (cGy): _____ Prescription Point: _____

Prescribed Dose per Fraction (cGy): No. of Fractions:

Treatment Length (mm):

Radionuclide: **Iridium-192** Activity as of Plan date (Ci): _____

Applicator Type: _____

No. of Channels: _____ No. of Dwell Positions: _____

Cylinder Info.

Type: _____

Length (mm): _____ Diameter (mm): _____

Special Instructions: _____

Radiation Oncologist Signature: _____ Date: _____

Comments:

Written Directive – Endobronchial treatment

Patient Name: _____

Medical Record Number: _____ Date of Birth: _____

Treatment Site: _____

Radiation Oncologist: _____

Plan ID: _____

Total Prescribed Dose (cGy): _____ Prescription Point: _____

Prescribed Dose per Fraction (cGy): _____ No. of Fractions: _____

Treatment Length (mm): _____

Radionuclide: **Iridium-192** Activity as of Plan date (Ci): _____

Applicator Type: _____

No. of Channels: _____ No. of Dwell Positions: _____

Catheters Info.

Type: _____

Length (mm): _____ Diameter (mm): _____

Special Instructions: _____

Radiation Oncologist Signature: _____ Date: _____

Comments:

Written Directive – Esophageal treatment

Patient Name: _____

Medical Record Number: _____ Date of Birth: _____

Treatment Site: _____

Radiation Oncologist: _____

Plan ID: _____

Total Prescribed Dose (cGy): _____ Prescription Point: _____

Prescribed Dose per Fraction (cGy): _____ No. of Fractions: _____

Treatment Length (mm): _____

Radionuclide: **Iridium-192** Activity as of Plan date (Ci): _____

Applicator Type: _____

No. of Channels: _____ No. of Dwell Positions: _____

Applicator Info.

Type: _____

Length (mm): _____ Diameter (mm): _____

Special Instructions: _____

Radiation Oncologist Signature: _____ Date: _____

Comments:

Written Directive – GYN: Ring and Tandem

Patient Name: _____

Medical Record Number: _____ Date of Birth: _____

Treatment Site: _____

Radiation Oncologist: _____

Plan ID: _____

Total Prescribed Dose (cGy): _____ Prescription Point: _____

Prescribed Dose per Fraction (cGy): No. of Fractions:

Treatment Length (mm):

Radionuclide: **Iridium-192** Activity as of Plan date (Ci): _____

Applicator Type: _____

No. of Channels: _____ No. of Dwell Positions: _____

Ring and Tandem Info. _____

Ring Diameter (mm): _____

Tandem Length (mm): _____ Tandem Angle (degree): _____

Special Instructions: _____

Radiation Oncologist Signature: _____ Date: _____

Comments:

E.14 Iridium-192 HDR Treatment Summary

Patient Name: _____

Medical Record Number: _____ Date of Treatment: _____

Treatment Site: _____

Radiation Oncologist: _____

Patient Identification (two or more): ☐ Spelling Name ☐ DOB ☐ Face Photo ☐ Wristband/Barcode

Source Configuration

Diagram/Comment

Applicator Type		
Catheter #	Channel #	Active Dwell Positions
Total number of dwell positions		

Total treatment time (sec): _____ Source activity (Ci): _____

Total treatment time x Source activity (sec x Ci): _____ Consistent with plan? ☐ Yes ☐No

Prescription

Reference Dose (Gy):		Reference Point:	

Physician Signature: _____ Date: _____

Physicist Signature: _____ Date: _____

Treatment

Treatment time (sec):		Reference Dose Delivered (Gy):	

Physician Signature: _____ Date: _____

Physicist Signature: _____ Date: _____

Patient & Room Survey

Pre-Treatment 1 meter from patient (mR/hr) _____ from afterloader (mR/hr) _____

Post-Treatment 1 meter from patient (mR/hr) _____ from afterloader (mR/hr) _____

Meter used: _____

Physicist Signature: _____ Date: _____