

**UMDNJ – UNIVERSITY HOSPITAL – RADIATION ONCOLOGY
Cs-137 BRACHYTHERAPY ADMINISTRATION PRESCRIPTION**

Patient Name: _____ **MR # :** _____

Procedure : 1-st 2-nd 3-rd 4-th 5-th

Intended Implant:

Radioisotope: Cs-137
Number
of Tube Sources: _____
Nominal Activity
of the Sources: _____

Authorized Physician Signature: _____ Date: _____

VERIFICATION of the PATIENT IDENTITY (check 2 or more):

Patient states Name Birth Date Address Social Security # ID Bracelet Photograph
 Hospital ID Card Med. Insurance Card Other: _____

Authorized Physician Signature: _____ Date: _____

Actual Implant:

Treatment Site
Applicator _____
Number of Tube Sources _____
Total Current Activity
(mg. Ra. eq.) _____
Dose to be Delivered
(cGy / mghr) _____
Duration of the Implant
(hr) _____

Authorized Physician Signature: _____ Date: _____

Adjustments to Treatment Plan: YES NO
If YES Specify:

Target Dose Delivered: _____ **cGy.** **Duration of the Implant:** _____ **hr.**

Authorized Physician Signature: _____ Date: _____