

**UMDNJ – UNIVERSITY HOSPITAL – RADIATION ONCOLOGY  
HDR BRACHYTHERAPY ADMINISTRATION PRESCRIPTION**

Patient Name: \_\_\_\_\_ MR #: \_\_\_\_\_

**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: \_\_\_\_\_

**Radioisotope Ir-192**

**HDR Unit: *GAMMAMED-12I AFTERLOADER***

Intended Treatment:

Treatment Site: \_\_\_\_\_

Total Dose to Deliver: \_\_\_\_\_ cGy.

Number of Fractions: \_\_\_\_\_

This Fraction Number:   1-st       2-nd       3-rd       4-th       5-th

This Fraction Applicator: \_\_\_\_\_

This Fraction Dose to Deliver: \_\_\_\_\_ cGy.

Authorized Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This Fraction Dose Deviated From the Treatment Plan:  YES  NO**  
**If YES Specify:**

**Total Dose Delivered to Date: \_\_\_\_\_ cGy.**

Authorized Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_