

**UMDNJ – UNIVERSITY HOSPITAL – RADIATION ONCOLOGY
Ir-192 BRACHYTHERAPY ADMINISTRATION PRESCRIPTION**

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

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

Implant Intended:

Radioisotope: Ir-192
Number of Ribbons: _____

Number of Seeds: _____

Activity per Seed: _____

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 _____

Number of Ribbons _____

Total Number of Seeds _____

Total Implant Activity
(mg.Ra.eq. / mCi) _____

Dose to be Delivered
(cGy) _____

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: _____