

UMDNJ – UNIVERSITY HOSPITAL – RADIATION ONCOLOGY
Sr-90 Intravascular 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: _____

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

Radioisotope Sr-90:

Active Transfer Device TDA-0030 **or Active Transfer Device TDA-0040**

Source Length: _____ mm. Current Activity: _____ GBq.

Treatment Site: _____

Applicator: **Novoste™ Beta-Cath™ IVB System.**

Target Point: _____

Target Dose: _____ Gy.

Planned Duration of the Application: _____ min. _____ sec.

Authorized Physician Signature: _____ Date: _____

Adjustments to Treatment Plan: YES NO
IF YES Specify:

Duration of the Application: _____ min. _____ sec.

Target Dose Delivered: _____ Gy.

Authorized Physician Signature: _____ Date: _____