Gleneagles Hospital
HONG KONG
港怡醫院

Hosp No.	:	HKID No.:	
Case No.	:		
Name	:		
DOB	:	M / F	
Adm Date	:		
Contact No.	:		

Brachytherapy Request Form

Radiotherapy and Oncology Department

Diagnosis:	
Pre-RT assessment:	❑ Patient is pregnant ❑ Patient is implanted with Cardiac Implantable Electronic Devices (e.g. Pacemaker, ICD) ***(Please refer patient for Cardiologist consultation)*** ❑ Patient received RT treatment previously in _____(hospital)_____(year) (***Please sign 2nd Course RT consent if applicable***)

Tentative Brachytherapy Treatment Scheme:

Dosage:	_____**Gy in** _____**fractions,** _____**fraction / week**
❑ *External RT*	_____*Gy given before brachytherapy*

Tentative first brachytherapy date:

Brachytherapy Detail:

❑ **Gynaecological Brachytherapy:**

❑ IGBT with ❑ CT plan (*Plain*) x ____frs. ❑ MRI (*Plain* 1 week before Brachytherapy
❑ MRI (*Plain*) plan x ____frs, and CT (*Plain*) plan x ____frs before consecutive day Rx

❑ Conventional brachytherapy with ❑ Orthogonal images for planning ❑ CT plan after first insertion

Vaginal Applicator Set: ❑ Intrauterine tube ❑ Cylinder

Multi-channel Applicator Set: ❑ Intrauterine tube ❑ Multi-channel ❑ Catheter with collar

Venezia Set: ❑ Intrauterine tube ❑ Ring ❑ ProGuide Round needle

Insertion Venue:	**GHK OT**	**RTO**
Type of Anaesthesia:	❑ General Anaesthesia ❑ Spinal Anaesthesia	❑ Local Anaesthesia ❑ Not Applicable
C-Arm X-ray:	❑	Not Available
USG:	❑	Not Available

Gynaecologist *(if applicable):* ***Dr:***_____ ❑ Informed ❑ Pending inform

Anaesthetist *(if applicable):* ***Dr:***_____ ❑ Informed ❑ Pending inform

❑ **Interstitial Brachytherapy:**

Site: _____ **OT Date:** _____

Surgeon (if applicable): ***Dr:***_____

❑ **Intraluminal Brachytherapy:**

Site: _____ **Endoscopy Date:** _____

❑ **Admission:** Expected length of stay ❑ _____ days

❑ _____ days/ week for _____ week

Signature of Referring Doctor: _____

Name in BLOCK LETTER / Chop: _____

Date: _____

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Remarks: