

February 12, 1997

Mr. W. L. Axelson, Director
Division of Radiation Safety and Safeguards
United States Nuclear Regulatory Commission
Region III
801 Warrenville Road
Lisle, IL 60532-4351

Oakland General
Hospital
Osteopathic

27351 Dequindre
Madison Heights, MI
48071-3499

810.967.7000

21-11494-01
030-02102

Dear Mr. Axelson:

Please be advised that we are planning to include in our Brachytherapy service the use of Iodine-125 seeds under 10 CFR 35.400 materials. Enclosed please find supplemental materials specifically designed for Iodine-125 permanent seeds used for prostate which are in addition to our previously submitted Quality Management program.

In addition, as we have amended our license, the radiation safety aspects of our brachytherapy service at Oakland General Hospital will be conducted by Dr. Farideh R. Bagne who as NRC well knows, has an excellent reputation in radiation safety aspects of therapeutic sources.

Should you have any questions, please contact Dr. Charles Feinman, the Hospital Radiation Safety Officer at (810) 967-7740, Dr. Bagne at (810) 542-0505, or myself at the above address.

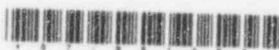
Sincerely,

Robert A. Deputat
President

c: Dr. Bagne
Dr. Bronn
Dr. Feinman
NCR file

enc.

RAD/mrh
C:\97chron\iodi125.doc



pm: 2-20-97

Holy Cross Hospital ■ Oakland General Hospital Osteopathic ■ River District Hospital
St. John Hospital - Macomb Center ■ St. John Hospital and Medical Center

St. John Behavioral Services ■ St. John-Bon Secours Senior Community ■ St. John Dialysis Centers ■ St. John Horizon Medical Equipment Services
St. John Flexstaff Services ■ St. John Home Care Services ■ St. John Medical Centers ■ St. John Rehabilitation Services
St. John Surgery Center

Member of the Sisters of St. Joseph Health System

RECEIVED

FEB 24 1997

REGION III

FEB 24 1997

**Oakland General Hospital
Madison Heights, Michigan
SPECIAL RADIATION ISOLATION ORDERS
Iodine-125 Prostate Seed Implant**

Addressograph

Activity _____	Assay Date _____	Site of Application _____
Patient Name _____		
Attending Physician _____		Phone _____
Date of Insertion _____		Time of Insertion _____
THIS PATIENT IS IN RADIATION ISOLATION UNTIL ORDERS ARE RESCINDED BY RADIATION ONCOLOGIST.		
1. No pregnant visitors or visitors under 18 years of age. Visitors should sit at least ____ feet from the patient and limit their stay to ____ minutes per day.		
2. Surgical dressings to be changed only by the physician or individual designated by him and trained in techniques applicable to such cases.		
3. In the event of the patient's death, contact the radiation oncologist and brachytherapy R.S.O. immediately at 542-0506 or on their pagers.		
4. At the time of discharge, please call MIRO at 542-0506.		
5. The room cannot be reused until monitored by the physicist.		
6. Additional instructions _____		

EXPOSURE RATES (mR/hr)					
Bedside	Behind Shield	One Meter	Six Feet	Date	Initials

IN CASE OF EMERGENCY, or for further information, call 542-0506

Radiation Oncologists/Medical Physicists	Phone	Pager
Donald G. Bronn, M.D., Ph.D.	542-0506	856-5000
Luciano M. DiCarlo, D.O.	542-0506	856-5006
Madhu Patel, M.D.	542-0506	856-5001
Farideh R. Bagne, Ph.D., J.D., Brachytherapy R.S.O.	542-0506	856-1234
Adib I. Shamaoun, Ph.D.	542-0506	856-5009
G. Michael Klein, M.S.	542-0506	856-5015

If unable to reach, contact OGH operator at 697-7000 for referral for home telephones.

*At time of patient discharge, send this form to the Radiation Safety Office at MIRO. Attn: Dr. Bagne

BRACHYTHERAPY PATIENT

NOTICE TO ALL PERSONNEL

CERTIFICATION OF RADIATION HAZARD STATUS

At _____ am / pm on _____ (date) the brachytherapy implant procedure of
_____ (patient) was completed and the patient was
discharged. Further radiation safety precautions are no longer required in connection with
this room.

Signature and Title

If any CAUTION signs have been left in place or if you have any questions about the
radiation status of this room, please call MIRO or the attending Radiation Oncologist.

Please return this form to MIRO or call 542-0506.

SAFROOM2.OGH 20Jan97

Holy Cross Hospital ■ Oakland General Hospital Osteopathic ■ River District Hospital
St. John Hospital - Macomb Center ■ St. John Hospital and Medical Center

St. John Behavioral Services ■ St. John-Bon Secours Senior Community ■ St. John Dialysis Centers ■ St. John Horizon Medical Equipment Services
St. John Flexstaff Services ■ St. John Home Care Services ■ St. John Medical Centers ■ St. John Rehabilitation Services
St. John Surgery Center



AFFILIATED RADIATION ONCOLOGY CENTERS

Oakland General Hospital Campus
27415 Dequindre • Madison Heights, MI 48071

(810) 542-0525
Fax (810) 542-3443

I-125 Prostate Seed Implant Needle Guidesheet

Patient Name _____ ID# _____ Date _____ Done By _____

inferior

Superior

Plane#										
Needle #										
1.....										
2.....										
3.....										
4.....										
5.....										
6.....										
7.....										
8.....										
9.....										
10.....										
11.....										
12.....										
13.....										
14.....										
15.....										
16.....										
17.....										
18.....										
19.....										
20.....										
21.....										
22.....										
23.....										
24.....										
25.....										
26.....										

Oakland General Hospital
Madison Heights, Michigan

Iodine-125 Therapy Administration
Limits of Exposure

Addressograph

Patient

Room

Administered Dose

mCi / Seed

Date

NURSES

1. Not more than _____ minutes in any one hour at bedside.
2. Not more than _____ minutes in any one hour at six (6) feet.

VISITORS

1. Not more than _____ minutes in any one hour at bedside.
2. Not more than _____ minutes in any one hour at six (6) feet (in chair).
3. Do not eat, smoke, drink, or apply cosmetics in patient's room.
4. Pregnant women or minors under 18 years of age should not visit the patient.
5. Visitors and neighboring patients should remain at a distance of more than six feet from patient.

IN CASE OF EMERGENCY, or for further information, call 542-0506.

Radiation Oncologists/Medical Physicists

Phone

Pager

Donald G. Bronn, M.D., Ph.D.

542-0506

856-5000

Luciano M. DiCarlo, D.O.

542-0506

856-5006

Madhu Patel, M.D.

542-0506

856-5001

Farideh R. Bagne, Ph.D., J.D., Brachytherapy R.S.O.

542-0506

856-1234

Adib I. Shamaoun, Ph.D.

542-0506

856-5009

G. Michael Klein, M.S.

542-0506

856-5015

If unable to reach, contact OGH operator at 967-7000 for referral for home telephones.

*At time of patient discharge, send this form to the Radiation Safety Office at MIRO.
Attn: Dr. Bagne

WRITTEN DIRECTIVE

IODINE-125 PROSTATE SEED IMPLANT

Patient _____ Date _____

ID# _____ Prescribed Dose _____

Number of Needles _____ Number of Seeds _____ Seed Strength _____ mCi

Date Ordered _____ Date of Implantation _____

Order _____ extra seeds for a total of _____ seeds

Clinical Information _____

Radiation Oncologist _____

Signature _____

WRITD125.OGH 31Jan97



AFFILIATED RADIATION ONCOLOGY CENTERS

Oakland General Hospital Campus
27415 Dequindre • Madison Heights, MI 48071

(810) 542-0525
Fax (810) 542-3443

NOTICE OF BRACHYTHERAPY TREATMENT

ULTRASOUND-GUIDED IODINE-125 PROSTATE SEED IMPLANT

NAME: _____ HOSPITAL # _____

MIRO #: _____ AGE: _____ DATE OF BIRTH: _____

REFERRING PHYSICIANS: _____

DIAGNOSIS: _____

=====

DATE OF TREATMENT: _____

SITE: _____ PRESCRIBED DOSE: _____

NEEDLE PLACEMENT BY UROLOGIST: _____

NUMBER OF NEEDLES _____ NUMBER OF SEEDS: _____

SEED STRENGTH: _____ mCi TOTAL ACTIVITY: _____ mCi

RESPONSE TO TREATMENT:

ADDITIONAL PROPOSED TREATMENT:

FOLLOW-UP SCHEDULE:

cc: Medical Records _____

RADIATION SAFETY SURVEY FORM

IODINE-125 PROSTATE SEED IMPLANT

Patient _____ **Room** _____ **Date** _____

Activity in mCi per seed _____

1. Sketch in room, include furniture and storage (urine.)
2. Indicate with numbers those locations to be surveyed.
3. Record values below.
4. Limit nurses and visitors to 2.5 mR in any hour.
5. Limit other patients to 100 mRem total--note time of scheduled discharge.
6. Make sure some diagnostic isn't interfering with the survey.
7. Rooms above, below and adjacent should be surveyed.
8. Upon completion of this form, return to Radiation Safety Office at MIRO.

Location

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

I125SURV.OGH 19Dec96

Holy Cross Hospital ■ Oakland General Hospital Osteopathic ■ River District Hospital
St. John Hospital - Macomb Center ■ St. John Hospital and Medical Center

St. John Behavioral Services ■ St. John-Bon Secours Senior Community ■ St. John Dialysis Centers ■ St. John Horizon Medical Equipment Services
St. John Flexstaff Services ■ St. John Home Care Services ■ St. John Medical Centers ■ St. John Rehabilitation Services
St. John Surgery Center

PATIENT IDENTIFICATION

IODINE-125 PROSTATE SEED IMPLANT

Patient Name _____

Date _____

Prior to the administration of any Seed, identify the patient by two or more of the following methods, then compare to the patient's record.

a. Patient's Name _____

b. Birth Date _____

c. Address _____

d. Social Security Number _____

e. ID Wrist Band / Hospital ID _____

f. Name on Patient's Medical Insurance _____

g. Photo of Patient's Face _____

h. Patient's Signature _____

Done By _____

Signature _____

I125PTID.OGH 19Dec96

Holy Cross Hospital • Oakland General Hospital Osteopathic • River District Hospital
St. John Hospital - Macomb Center • St. John Hospital and Medical Center

St. John Behavioral Services • St. John-Bon Secours Senior Community • St. John Dialysis Centers • St. John Horizon Medical Equipment Services
St. John Flexstaff Services • St. John Home Care Services • St. John Medical Centers • St. John Rehabilitation Services
St. John Surgery Center

A member of the Sisters of St. Joseph Health System

ULTRASOUND PROSTATE IMPLANT FLOWSHEET

810.967.7000

Patient: _____ Physician: _____ Date: _____ Done By: _____

I. Preliminary Studies

Consult Done	Y	N	Date _____
Initial Simulation Films Taken-Complex	Y	N	Date _____
CT Scan for Pubic Arch Study Done	Y	N	Date _____
Ultrasound Volume Study Done	Y	N	Date _____
Ultrasound Images Labeled as to Sequence	Y	N	Date _____
Target Volume Indicated on each Image	Y	N	Date _____
Urethra Marked if Sparing Desired	Y	N	Date _____
Tumor Volume Marked if Special Loading Desired	Y	N	Date _____
Special Dosimetry Instructions for Pre-Plan			
Desired Isotope _____	Desired MPD _____	Gy	Prospective Implant Late _____

II. Pre-Plan

Ultrasound Volume Study Sent to Dosimetry	Y	N	Date _____
Number of Seeds Required by Plan _____	Plus _____	Extra _____	
Activity of Individual Seeds = _____	mCi for MPD = _____	Gy	
Total Number of Contours Planned _____			
Pre-Plan Approved by Physics	Y	N	Date _____
Pre-Plan Returned to Radiation Oncologist for Approval	Y	N	Date _____
Pre-Plan Reviewed and Approved by Radiation Oncologist	Y	N	Date _____

III. Ordering

Written Directive Part I completed	Y	N	Date _____
Seeds Ordered	Y	N	Date _____
Delivery Date Chosen as _____	Y	N	
Number of Seeds Ordered _____	of Activity _____	/ assay Date _____	
Copy of Prescription Sent to OGH Nuc Med	Y	N	Date _____

IV. Day of Implantation

Physician Signed a Written Directive, Parts II, III	Y	N	Date _____
Two Methods of Patient ID Documented	Y	N	Date _____
All Factors Checked Prior to Treatment	Y	N	Date _____
Treatment Pre-Plan Signed by Two People	Y	N	Date _____
Treatment Pre-Plan Signed by Radiation Oncologist	Y	N	Date _____
Treatment Administered without Problems	Y	N	Date _____
Patient Surveyed	Y	N	Date _____
All Seeds Accounted for After Implantation	Y	N	Date _____
Patient Given Post-Implant Instructions, Pb Packet & Strainer	Y	N	Date _____
All Radioactive Signs Removed and Stored after Patient Release	Y	N	Date _____
Post-Implant Simulation Films Taken-Complex	Y	N	Date _____

V. Post-Implantation

Check Simulation Films Taken-Simple	Y	N	Date _____
CT Scan of Pelvis with 0.5 cm cuts Done	Y	N	Date _____
Post-Treatment Verification Plan Done	Y	N	Date _____
Post-Treatment Plan Signed by Two People	Y	N	Date _____
Post-Treatment Plan Signed by Radiation Oncologist	Y	N	Date _____
Written Directive Part IV Completed	Y	N	Date _____

Answers of "NO" should be explained if not self-explanatory.

1125SAFE. OGH 19Dec96

Holy Cross Hospital • Oakland General Hospital Osteopathic • River District Hospital
St. John Hospital - Macomb Center • St. John Hospital and Medical Center

St. John Behavioral Services • St. John-Bon Secours Senior Community • St. John Dialysis Centers • St. John Horizon Medical Equipment Services
St. John Prosthetic Services • St. John Home Care Services • St. John Medical Centers • St. John Rehabilitation Services
St. John Surgery Center

A member of the Sisters of St. Joseph Health System

PROCEDURE FOR ORDERING I-125 SEEDS

1. Use standing purchase order # _____ from Oakland General Hospital.
2. Determine the activity of the I-125 seeds (6711, I-125, type 109) from the pre-plan _____ mCi of type _____.
3. Determine the total number of seeds _____.
4. Check with the radiation oncologist to ensure the written directive is completed.
5. Oakland General's NRC License is #21-11494-01.
6. Oakland General's Amersham account # is 48071-03
7. Call: Amersham Healthcare
Medi-Physics, Inc.
2636 S. Clearbrook Dr.
Arlington Heights IL 60005
Customer Service 1 800 228 0126
Technical Information 1 800 554 0157
- Give: --Total # of I-125 Seeds _____
--Type of Seed: Type 109, 6711
--Activity per Seed _____
--Date of Insertion _____
--Date of Delivery _____
--Location of Delivery: Hand deliver to Nuclear Medicine Dept. @ OGH
--Your Name _____
--Give MIRO's phone # (810) 542 0505.
--Refer to Oakland General's Account and Purchase Order numbers.
8. Fax a copy of the prescription to OGH Nuclear Medicine @ 967-7299, attn: Tom Marsh.
9. Amersham's Order Number _____
10. File this sheet in nurse's I-125 patient book and a copy in the patient's MIRO chart.
11. Patient _____ Order date _____
I125ORDR.OGH 31Jan97



AFFILIATED RADIATION ONCOLOGY CENTERS

Oakland General Hospital Campus
27415 Dequindre • Madison Heights, MI 48071

(810) 542-0525
Fax (810) 542-3443

CT-Based Pubic Arch Interference Study for I-125 Prostate Seed Implant Patients

To: _____ Donald G. Bronn, MD, PhD _____ Ahmed E. Ezz, MD, FRCP(C)
_____ Luciano M. DiCarlo, DO _____ Madhu Patel, MD

From: Farideh R. Bagne, PhD, JD

Date:

Patient Name: _____

Utilizing the Treatment Planning CT Scan, I have evaluated the position of the pubic arch in relation to the prostate gland.

_____ The arch should not impede the progress of the brachytherapy needles.

_____ The arch will interfere with the treatment.

_____ Other:

Done By:

Physician:

PUBARCH.OGH 17Jan97

Date: _____

To Patient: _____

You have selected to have a radioactive seed implantation to the prostate performed at Oakland General Hospital in Madison Heights, Michigan, for your prostate cancer.

The purpose of this letter is to inform you that, if for any reason, it is necessary for you to cancel your scheduled procedure:

WE MUST RECEIVE WRITTEN NOTIFICATION OF YOUR DESIRE TO CANCEL OR POSTPONE YOUR PROCEDURE AT LEAST TEN (10) DAYS PRIOR TO THE SCHEDULED SURGERY. IF WE DO NOT RECEIVE SUCH NOTIFICATION, IT WILL BE NECESSARY TO CHARGE YOU THE COST OF THE RADIOACTIVE SEEDS EVEN THOUGH THEY ARE NOT USED.

We regret the necessity for this policy. The seeds are individually ordered for each patient and therefore cannot be easily transferred to another patient; they also have a "limited lifespan" and cannot be held for a significant period of time without being used. When the seeds are shipped to Oakland General, the Hospital is then responsible to the manufacturer for the cost of the seeds, whether or not they are used. Depending on the number and type of seeds ordered, this cost could range from a minimum of \$1,500.00 to more than \$3,500.00 for which you would be held responsible.

We regret any inconvenience that this policy may cause you and trust that you will understand the necessity for it.

Sincerely,



Donald G. Bronn, MD, PhD
Chief, Radiation Oncology Services
Oakland General Hospital

I have read and agree with the above terms and conditions.

Date _____ Time _____ AM/PM

Patient's Signature _____

Witness _____
SEEDCOST.OGH 19Dec96

CONSENT FORM-IODINE-125 PROSTATE SEED IMPLANT

I _____ know that I have a condition requiring radiation therapy. I have authorized Drs. _____ and Associates to perform the radiation therapy procedure known as **Ultrasound-Guided Iodine-125 Prostate Implant Brachytherapy**. I understand that this procedure is for the purpose of **controlling prostate cancer** and, although no specific result has been guaranteed, it is expected to **kill cancer cells in the prostate gland**. I understand that **POSSIBLE** complications are as follows: **Immediately post-op: slight bleeding beneath the scrotum; blood in the urine; bruising and tenderness between the legs. Later: frequent urination; burning with urination; sense of urgency; weakened urinary stream. Possible long term side effects: narrowing of the urethra; impotence; loss of bladder control; damage to bladder; damage to rectum; rare risk of seed migration into a lung; or, rare risk of seed migration into ejaculatory fluid.**

I understand that an identification photograph of my face will be taken. In addition, photographs may be taken of me or parts of my body to be used for medical records. Also, if in the judgement of my physicians, medical research, education, or science will be benefitted by their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books or used for any other purpose which they may deem proper in the interest of medical education, knowledge or research, provided, however, that it is specifically understood that, in any such publication or use, I shall not be identified by name.

I acknowledge that the doctors have explained to me the nature and purpose of the procedure and what the procedure is expected to accomplish, together with the known risks. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the operation or procedure. Possible alternate methods of treatment, if any, have been explained, as have the results likely if I remain untreated.

With a full understanding of all the foregoing, and realizing that no guarantee or assurance has been given by anyone as to the results that may be obtained from this therapy, I do hereby request and authorize Drs. _____ and Associates and whomever they may designate to assist them to administer radiation treatments with **Iodine-125** radioisotope therapy to me.

Date _____ Time _____ AM/PM

Signature of Patient _____

Signature of Closest Relative or Legal Guardian _____

Physician's Signature _____

Witness _____

I125IMPL.OGH 20Jan97

Brachytherapy Service
Radiation Oncology Quality Assurance Management Program
Written Directive to be used with _____

PART I

Patient Name _____ Room # _____
History Number _____ Date of Treatment _____
Attending Physician _____
Indication(s) _____
Procedure _____
Radiopharmaceutical Sr-89 P-32 I-125 Pd-103
Dosage _____ mCi or Gy Route _____
Authorized User
Signature _____ Date _____

PART II

Ordered for _____ MD / DO Date Ordered _____
Assayed by _____ Date Assayed _____
Assayed Value _____ Ordered by _____ (Physicist)

PART III

The patient's identity must be verified by at least two of the following:

____ Patient called by name
____ Patient spelled his/her name
____ Patient stated date of birth
____ Patient stated social security number
____ Patient provided positive identification
____ Is patient pregnant?
____ Is patient breast feeding?
____ Booklet given and reviewed?
____ Consent signed?
____ Wrist bend verified?

Patient identification verified by _____

PART IV

DOSE ADMINISTERED ON (Date) _____ (Time) _____
Actual Dose Delivered _____ mCi
Authorized User _____ Date _____ Bioassay needed?
Y N
Medical Physicist _____ Date _____ Y N
(Signature above indicates presence at administration and assurance that this written directive was followed.)

BRACHQA.OGH 19Dec96

Holy Cross Hospital ■ Oakland General Hospital Osteopathic ■ River District Hospital
St. John Hospital - Macomb Center ■ St. John Hospital and Medical Center

St. John Behavioral Services ■ St. John-Bon Secours Senior Community ■ St. John Dialysis Centers ■ St. John Horizon Medical Equipment Services
St. John Flexstaff Services ■ St. John Home Care Services ■ St. John Medical Centers ■ St. John Rehabilitation Services
St. John Surgery Center

BRACHYTHERAPY PATIENT

NOTICE TO ALL PERSONNEL-OPERATING ROOM

CERTIFICATION OF RADIATION HAZARD STATUS

At _____ am / pm on _____ (date) the brachytherapy implant of
_____ (patient) was completed. Further radiation safety
precautions are no longer required in connection with this room.

Signature and Title

If any CAUTION signs have been left in place or if you have any questions about the radiation status of this room, please call MIRO or the attending Radiation Oncologist.

Please return this form to MIRO or call 542-0506.

SAFEROOM.ORG 20Jan97

Holy Cross Hospital • Oakland General Hospital Osteopathic • River District Hospital
St. John Hospital • Macomb Center • St. John Hospital and Medical Center

St. John Behavioral Services • St. John-Bon Secours Senior Community • St. John Dialysis Centers • St. John Horizon Medical Equipment Services
St. John Flexstaff Services • St. John Home Care Services • St. John Medical Centers • St. John Rehabilitation Services
St. John Surgery Center

DISCHARGE INSTRUCTIONSRADIOACTIVE SEED IMPLANTFOR PROSTATE CANCER

1. You may notice some blood in your urine. This is normal and should subside in approximately 24 hrs. If after 24 hrs the bleeding persists or you begin to pass blood clots, you should contact your urologist.

It is common to experience frequent urination, burning with urination, a sense of urgency or a decrease in the force of the urinary stream. These symptoms will gradually decrease as the seeds lose their strength, but may be present to some degree for 6-12 months after the implant. Drink plenty of fluids and avoid caffeine containing beverages to help relieve the symptoms.

2. If you experience any light-headedness, dizziness or a temperature over 100°, please contact your urologist right away.
3. Avoid heavy lifting or strenuous physical activity for two days. After that, you may return to normal activity.
4. No restriction on your travel or physical contact with other adults. If a child or pregnant woman is in the same room as you for more than 5-10 minutes, they should stay 6 feet or more away. Since the radiation is coming from the prostate, children should not sit on your lap during the initial 2 month period following the implant. Do not sleep in the same bed as a pregnant woman or child.
5. Although rare, an occasional seed may be lost via urination within the first week following the implant procedure. If a seed is passed, it should be retrieved and returned to the Michigan Institute for Radiation Oncology. Strain your urine for the first week following the implant. If a seed is passed, it should be picked up with tweezers and placed in the packet provided.
6. A seed may rarely be passed with the ejaculate during intercourse. Use a condom during intercourse for the first two months following the implant procedure so that any possible seed can be retrieved. It is normal for the ejaculate to be discolored dark brown to black for up to several weeks following the implant procedure. Sexual intercourse may be resumed after two weeks.

7. Objects that you touch or items that are used do not become radioactive. Bodily wastes (urine and stool) are not radioactive.
8. Antibiotics are given after the implant to prevent infection. You should take the antibiotic as prescribed by your physician until the medication runs out. If you develop an allergic reaction, such as a skin rash, stop the medication and contact your physician.

Appointment at MIRO _____

CT Scan _____

Urologist _____

If you have any questions or problems, call your urologist
at _____ or the Michigan Institute
for Radiation Oncology at (810) 338-0300.

Date _____ Time _____ AM / PM

Patient's Signature _____

Witness _____



AFFILIATED RADIATION ONCOLOGY CENTERS

Oakland General Hospital Campus
27415 Dequindre • Madison Heights, MI 48071

(810) 542-0525
Fax (810) 542-3443

NURSING CHECKLIST

RADIOACTIVE SEED IMPLANT-PROSTATE

Patient	_____
Urologist	_____
Consultation Date	_____
Simulation	_____
CT Scan	_____
Ultrasound	_____
Surgery Date	_____
Patient teaching:	
Video viewed by patient	_____
Patient information Booklet	_____
Discharge Instructions-Surgery	_____
Antibiotic Rx -Urologist	_____
Consents:	
Notification of Seed Charge	_____
Iodine-125 Prostate Seed Implant Consent	_____
Surgical Preparation to be Ordered by Urologist:	
Two (2) Fleets enemas am of Surgery	_____
CBC, Electrolyte, PT, PTT	_____
PAT	_____
CT Pelvis-Post Surgery	_____
Simulation Post Surgery	_____
Appointments:	
Urologist	_____
MIRO	_____

Radioactive Seed Implant Prostate

[illegible]