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|  | | **Cancer Center of Southeastern Ontario**  **HDR Brachytherapy Program**  **Treatment Delivery Record**  (Gynae, Esophagus & Lung) |
| Patient Name | <Full Name> | |
| Patient ID1 (CR Number) | <Patient Id 1> | |
| Date of Birth | <Date of Birth> | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Fraction Number** | |  |  |  |  |  |
| **Date (dd/mm/yy)** | |  |  |  |  |  |
| **Treatment Unit** | |  |  |  |  |  |
| **Isotope** | | **Ir-192** | **Ir-192** | **Ir-192** | **Ir-192** | **Ir-192** |
| **Total Number of Channels** | |  |  |  |  |  |
| **Applicator** | |  |  |  |  |  |
| **Source Strength (cGy-cm2/hr) on Tx Day** | |  |  |  |  |  |
| **Total Dwell Time(s)** | |  |  |  |  |  |
| **Pre-Tx Physics Check (MP)** | |  |  |  |  |  |
| **Treatment Authorized (RO)** | |  |  |  |  |  |
| **Dose Delivered In This Fraction (cGy)** | |  |  |  |  |  |
| **Cumulative Dose To Date (cGy)** | |  |  |  |  |  |
| **Treatment Delivered By (RT)** | **M.R.T. (T) 1** |  |  |  |  |  |
|  | **M.R.T. (T) 2** |  |  |  |  |  |
| **Post Tx Physics Check / Date** | |  |  |  |  |  |
|  | |  |  |  |  |  |

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| **Setup Instructions (Please specify below):** |
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