MonashImaging
MonashHealth

Pre Breast Surgery Request Form

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Identity

Patient Name:
UR:
DOB: M / F
Address:

Phone: Mobile:
(Affix Patient's ID label here)

Is an interpreter required Y ☐

Language .....

Cubicle / Ward / Other Unit

DI Use only
Appt Date & Time

Referring Consultant Details

(Print) Name ..... **Provider number:** .....

Pager No ..... Fax No ..... Phone No ..... Mobile .....

Address: .....

Registrar Name: .....Pager/Mob No .....

Situation

Clinical Details

Lesion Sites:

1. Ultrasound: **Side: .....**

Size: .....

..... o'clock

..... cm FN

2. Mammography **Side: .....**

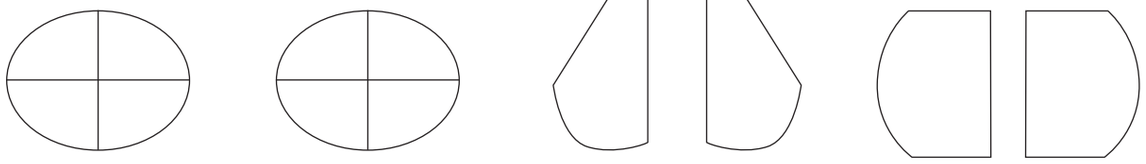
Lesion Type:

☐ **Microcalcification**

☐ **Mass**

☐ **Other**

RIGHT BREAST **LEFT BREAST**



Background

Date & Time of Breast Surgery: .....

Date & Time of Sentinel node Procedure: .....

Date & Time of Localisation: .....

Previous Breast Imaging at: .....

Assessment

Case discussed with Radiologist Y / N **Radiologist initials** ..... **Preferred modality US / Mammo**

Request

For ☐ **Hookwire Only** ☐ **Iodine seed I-125**
☐ **Sentinel Procedure Only**

Number of Lesions to be Localized

1. Single:.....

2. Multiple:.....

Localisation Method
☐ **Ultrasound**
☐ **Mammography**

Number of Wires/Seeds
☐ **One** ☐ **Two** ☐ **> Two**

Campus .....

SENTINEL PROCEDURE:

Date of Injection..... **Site of Lesion in Breast:.....**

Site of Injection:

☐ **Periareolar** ☐ **Peritumoural**

Lymphoscintigram: ☐ **Yes – Up to .....hrs** ☐ **No**

.....
Signature of Consultant/Registrar

.....
Date

RIS LABELS *RIS LABELS* *RIS LABELS*

MIT / NMT / Sono 3C

Correct Patient

(Patient to state, Full name, DOB, Address) where practical

Please tick 3 relevant Patient Identifiers before commencing examination

Full name ☐ DOB ☐ Address ☐ Wristband ☐ Ankleband ☐

Ward / ED staff / Relative assisted with identity of patient ☐

Pregnancy Check

N/A ☐

Patient states "NOT" pregnant? Confirmed ☐

bHCG Value:(if applicable) .....

Correct Procedure Yes ☐ No ☐ (Patient verification with clinical history as required)

Correct Side/Site Yes ☐ No ☐ N/A ☐ **MIT / NMT /Sono (Signature):** .....

Verified-Post procedure side matching +/-laterality

Intervention Team

Time Out (Interventional studies only, checklist completed by scout nurse)

NB: Performed immediately prior to commencement of intervention.

1. Correct patient verified? Yes ☐ Safe to proceed, step (2)
2. Procedure matches consent? Yes ☐ Safe to proceed, step (3)
3. Correct side/site identified and marked with indelible pen? Yes ☐ N/A ☐ Safe to proceed, step (4)
4. L/R orientation confirmed on in-room monitor/image acquisition system Yes ☐ N/A ☐ Safe to proceed
   MIT (initial) .....

Date: ..... *Time:* .....

Proceduralist / fellow / registrar: (PRINT name): ..... Nurse/MIT/Sono: .....

Signed Proceduralist / fellow / registrar .....

Radiologist

Examination Details

Protocol:

Code: ..... Dr Initials: .....

Machine preference, ...

I.V. Contrast required Yes ☐ No ☐

Oral Contrast required Yes ☐ No ☐

Recall details / sequences as required: .....

Cleri-cal

Films to be printed ☐ Comments: .....

CD to be burnt ☐ .....

Patient to take ☐ .....

MIT / NMT / Sono

RIS Procedure details

Radiation Dose / Fluoroscopy time:

Radiologist / NM Physician:

MIT/NMT:

Contrast Medium & Batch No:

Type / Volume:

Contrast Reaction? Yes ☐ No ☐

Time when oral contrast given:

Examination comments (free text)

(no disparaging or inappropriate comments about the patient allowed here)

☐ Patient uncooperative-movement
☐ No images obtained
☐ Some images obtained
☐ Pt Claustrophobic
☐ Pt rebooked for sedation
☐ Pt refused sedation