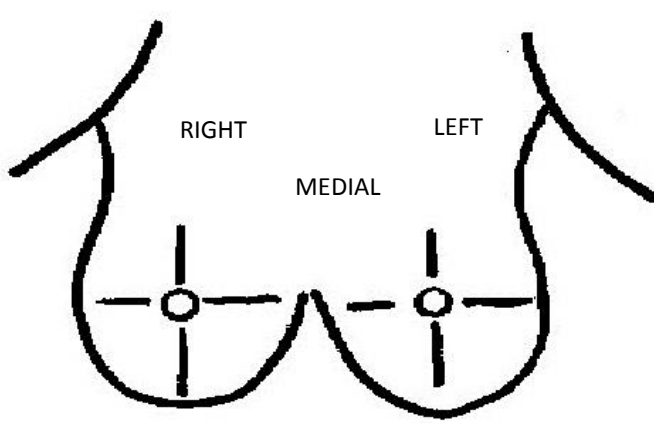


Patient Label here

Preoperative Breast Localization Booking

Patient Information	
Patient Name:	Surgery Appointment
MRN:	Date: _____ (mm/dd/yyyy)
Health Card Number:	Appointment Time: _____ <input type="checkbox"/> am <input type="checkbox"/> pm
Date of Birth: (dd/mm/yyyy)	Radiation Seed Localization Appointment (RSL)
Referring Physician/Surgeon:	Date: _____ (dd/mm/yyyy)
	Appointment Time: _____ <input type="checkbox"/> am <input type="checkbox"/> pm
	Sentinel Lymph Node (SLN) Injection Appointment
	Date: _____ (dd/mm/yyyy)
	Appointment Time: _____ <input type="checkbox"/> am <input type="checkbox"/> pm
Consent: <input type="checkbox"/> Enclosed (Signed by patient or substitute decision maker)	
RSL information sheet given to patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Preoperative SLN Nuclear Medicine Injection required: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left	
Preoperative Breast Localization <input type="checkbox"/> Ultrasound <input type="checkbox"/> Mammography	
Please check one	
Lesion 1: <input type="checkbox"/> Breast RT <input type="checkbox"/> Breast LT OR <input type="checkbox"/> Axilla RT <input type="checkbox"/> Axilla LT	
Lesion location/o'clock: _____ _____ single seed _____ bracketing (two seeds)	
Lesion 2: <input type="checkbox"/> Breast RT <input type="checkbox"/> Breast LT OR <input type="checkbox"/> Axilla RT <input type="checkbox"/> Axilla LT	
Lesion location/o'clock: _____ _____ single seed _____ bracketing (two seeds)	
Is the patient taking blood thinners? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relevant History/Comments:	

