Scheduling Form For Breast Lymphoscintigraphy

Date	
Time	
Location	North South

I. To Be Completed By Referring Physician

1. Patient: _____ Sex: ☐ M ☐ F
2. Date Of Birth: _____
3. Physician:_____ Physician Phone/Beeper:_____
4. Side of Breast Cancer(select one): ☐ Right ☐ Left
5. Location of Breast Cancer(select all that apply, usually 2)
   ☐ Upper ☐ Lower ☐ Central ☐ Inner ☐ Outer
6. Size of the Breast Cancer: _____ by _____cm.
7. Needle localization required? Yes ____ No _____

   If Yes, patient goes to the **Breast Center** after the injection and returns to nuclear medicine for imaging after needle localization.

   Call Breast Center scheduler (pager 360-2712) to schedule needle localization

   Time of Needle Localization _____
8. Day/Time of Surgery: ☐ Same Day/Time_____ ☐ Next Day/Time_____
9. Location of Surgery: ☐ North Campus ☐ South Campus
10. _____ _____ _____

    Date | Person completing scheduling form | Telephone number
11. Fax this form to Nuclear Medicine and call Nuclear Medicine to confirm receipt

North Campus - Fax: 454-8254 Phone: 454-8945
South Campus - Fax: 362-0414 Phone: 362-1952

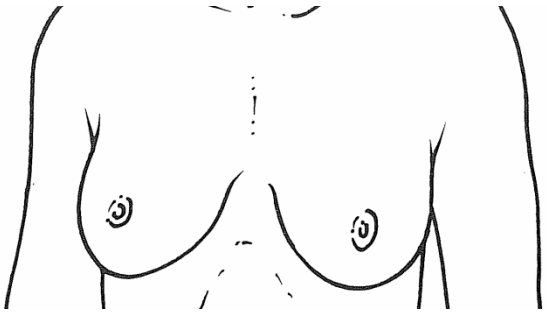
II. Scheduling form reviewed by

_____ _____

Attending Nuclear Medicine Physician ***Date***

III. To Be Completed By Nuclear Medicine

1. Technologist Who Performed the Injection:_____
2. Site(s) of injection



Right Left