Scheduling Form For Breast Lymphoscintigraphy

Date	
Time	
Location	☐ **BJH-North** ☐ **BJH-South** ☐ **BJWCH**

I. To Be Completed By Referring Physician

1. Patient: _____ Sex: ☐ M ☐ F
2. Date of Birth: _____
3. Physician: _____ Phone/Beeper: _____
4. Side of Breast Cancer (select one): ☐ Right ☐ Left
5. Location of Breast Cancer: Indicate clock position in breast _____ O'clock
6. Needle localization required? ☐ Yes ☐ No
   Time of Needle Localization _____
7. Day/Time of Surgery: ☐ Same Day/Time _____ ☐ Next Day/Time _____
8. Location of Surgery: ☐ BJH-North ☐ BJH-South ☐ BJWCH
9. _____ _____ _____
   Date Person completing scheduling form Telephone number
10. **Fax this form to Nuclear Medicine and call Nuclear Medicine to confirm receipt**

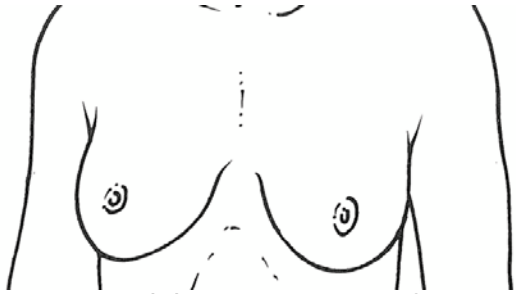
BJH-North:	Fax: 454-8254	Phone: 454-8945
BJH-South:	Fax: 362-0414	Phone: 362-1952
BJWCH:	Fax: 996-8716	Phone: 996-8497

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