



BREAST SURGERY PRE-OPERATIVE CHECKLIST

To Be Completed by Surgeon's Clinic	To Be Completed by Slating / Nurse / Designate
CancerCare Nurse Navigator Consulted: <input type="checkbox"/> Yes <input type="checkbox"/> No	CancerCare Nurse Navigator Consulted: <input type="checkbox"/> Yes <input type="checkbox"/> No
Possible OR Dates: _____ dd/mm/yyyy _____	Confirmed OR Date: _____ dd/mm/yyyy
OR Slating Form completed <input type="checkbox"/> Yes <input type="checkbox"/> No	OR Slating Form <input type="checkbox"/> Yes <input type="checkbox"/> No
Consent to Procedure Treatment or Investigation <input type="checkbox"/> Yes <input type="checkbox"/> No	Consent to Procedure Treatment or Investigation <input type="checkbox"/> Yes <input type="checkbox"/> No
PreOperative History & Physical Form <input type="checkbox"/> Yes <input type="checkbox"/> No	PreOperative History & Physical Form <input type="checkbox"/> Yes <input type="checkbox"/> No
DSM Breast Pathology Requisition completed <input type="checkbox"/> Yes <input type="checkbox"/> No	DSM Breast Pathology Requisition completed <input type="checkbox"/> Yes <input type="checkbox"/> No
Pathology Report from Core Biopsy attached <input type="checkbox"/> Yes <input type="checkbox"/> No	Pathology Report from Core Biopsy attached <input type="checkbox"/> Yes <input type="checkbox"/> No
Mammogram (and Ultrasound) report attached <input type="checkbox"/> Yes <input type="checkbox"/> No	Mammogram (and Ultrasound) report attached <input type="checkbox"/> Yes <input type="checkbox"/> No
Physician Order Sheet <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician Order Sheet <input type="checkbox"/> Yes <input type="checkbox"/> No
Sentinel Lymph Node Injection: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>To be booked day before surgery, last injection of the day)</i>	Sentinel Lymph Node Injection: <i>To be booked day before surgery, last injection of the day)</i>
Diagnostic imaging requisition completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Faxed Date: _____ dd/mm/yyyy Initials: _____
Location of Sentinel Lymph Node Injection: _____	Appointment Date: _____ dd/mm/yyyy Time: _____
	Patient Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date Notified: _____ dd/mm/yyyy Initials: _____
Ultrasound Guided Needle Localization: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(To be booked day of surgery, first appointment of the day)</i>	Ultrasound Guided Needle Localization: <i>(To be booked day of surgery, first appointment of the day)</i>
In Sixty Requisition for Hospital Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a	In Sixty requisition for Hospital completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
Specimen Imaging: <input type="checkbox"/> Yes <input type="checkbox"/> No	Faxed Date: _____ dd/mm/yyyy Initials: _____
<input type="checkbox"/> Westman/Brandon Diagnostic Imaging Requisition Completed	Appointment Date: _____ dd/mm/yyyy Time: _____
	Patient Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date Notified: _____ dd/mm/yyyy Initials: _____