Meet McLaren

THERASPHERE™ Y-90 MICROSPHERES

TheraSphere Y-90 is a targeted liver cancer therapy with low toxicity, consisting of millions of tiny glass beads containing radioactive Yttrium-90. The glass beads (15-35 micrometers in diameter, about a third of the width of a human hair) are delivered directly to tumors located in the liver. Treatment with TheraSphere is commonly referred to as selective internal radiation therapy (SIRT), transarterial radioembolization (TARE), or simply radioembolization.

Treatment with TheraSphere is typically done during an outpatient procedure and is well tolerated by patients with side effects that are normally milder than many other liver cancer treatments. After treatment, most patients are able to undergo additional therapies as needed given the procedure does not block the vessels of the liver.

YOUR PATIENT MIGHT BENEFIT FROM THIS TREATMENT IF:

- Your patient has cancer that is in the liver (hepatocellular carcinoma or HCC), metastatic disease to the liver, or colorectal cancer
- Your patients is a candidate for a liver transplant and their liver cancer needs to be treated while a patient waits for a liver.
- Your patient has a liver/colorectal cancer that can't be removed by surgery.

McLaren
GREATER LANSING

CONTACT US

Karmanos Cancer Institute
Oncology Navigators
3520 Forest Road, First Floor
Lansing, MI 48910

Monday-Friday: 8 am - 4 pm

Benjamin J Pomerantz, MD
Interventional Radiology Specialist
(517) 975-7727
benjamin.pomerantz1@mclaren.org

Referrals from McLaren Greater Lansing providers:
Submit the referral through Cerner using "Referral to Interventional Radiology" and then choose the Mclaren Greater Lansing location. A form populates to be filled out by the referring physician and will be sent to IR.

Providers referring outside of McLaren Greater Lansing:
Please fill out the referral form on the back or fax an order printed from your EMR along with patient demos, radiology reports, and office notes. Please fax to 517-975-8804.

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INTERVENTIONAL RADIOLOGY REQUEST/HISTORY&PHYSICAL

Referring Physician/office staff to complete:

Patient Name: _____D.O.B._____

Patient Phone Number: _____Cell Phone: _____

Insurance:_____Pre Auth #:_____

PCP Name:_____History of Kidney Disease? Yes No / History of Tobacco Use? Yes No

Requesting Physician Name: _____Phone Number:_____

Prior Imaging Studies: _____Where: _____

Allergies: _____Latex allergy? Yes No Contrast Allergy? Yes No

Meds (may attach list): _____Interpreter Needed: Yes No

PT/PTT done in past 7 days? Yes No Is patient on anticoagulation/antiplatelet ? yes no if yes name of medication_____

Referring Physician to Complete:

Procedure Requested: _____Reason for Procedure:_____

Brief History: _____

Mental Status_____Social History_____

Pertinent past medical/surgical History: _____

Vitals: temp_____pulse_____resp_____BP_____/_____

Pertinent Review of Systems: _____

Physical Exam: Heart: Normal Abnormal _____

Lungs: Normal Abnormal: _____

Abdomen:_____

Other: _____

Assessment and Plan: _____

Referring Physician Signature: _____Date: _____

Radiologist to Complete: (please circle)

Modality to use: Ultrasound CT Scan Special Procedures

Cytology Tech needed: Yes No

Patient Position: Supine Prone Oblique

Contrast Type Oral IV

COMMENTS: _____

Refer to slice numbers from previous Imaging: _____

Choose one: Formalin B5-Fix Flow Cytometry Slides Culture

Estimated Time for Procedure: 30 mins 60 min. 90 mins 2 HRS. Other:

Lab work necessary? Yes No If yes: PTT INR BUN Creatinine CBC Other:

Other Information/Instructions: _____

Radiologist Completing worksheet: _____Date: _____

Appt. Date:_____Time:_____Patient Arrival Time:_____

RN office phone: 517-975-7727 **RN office fax: 517-975-8804** Groupwise_____ Paragon_____

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