Particle Beam Radiation Therapy Referral Fax Form (1)

Fax No.: Japan 0791-58-2600

To: Hyogo Ion Beam Medical Center

Patient Medical Information Form

● Information about Your Hospital/Clinic Fax Remittance Date_____ MM/DD/YYYY

Name of the Hospital/Clinic _____

Address: _____

Department _____ Tel.:_____ Fax: _____

Name of Physician _____ Name of Nurse in Charge _____

e-mail: _____

● Information about the Patient Requesting second opinion only Yes No

Name: (First) _____ (Middle) _____ (Last) _____ [Male Female]

Date of Birth _____ MM/DD/YYYY Age _____

Address _____

Tel.:_____ Fax: _____

Main Complaint:_____

Diagnosis: _____

Pathological Diagnosis: _____

TNM Category T_____ N_____ M_____ Stage_____ Unknown

Date of Recent Blood Test (MM/DD) WBC_____ Plt_____ Hb_____ Creatinine Level_____

Complications □ Present □ Not present Details ( )

Past Cancer Treatment □ No □ Yes (□ Surgery □ Chemotherapy □ Radiation Therapy □ IVR □ Other)

Details of Explanations Made to the Patient
( )

History of Present Illness:

Contact:
Hyogo Ion Beam Medical Center
http://www.hibmc.shingu.hyogo.jp/
Tel.: Japan 0791-58-0100 (Main)
Fax: Japan 0791-58-2600

Particle Beam Radiation Therapy Referral Fax Form (2)
Fax No.: Japan 0791-58-2600
To: Hyogo Ion Beam Medical Center

Skull Base Tumor Check Items/Test Items

1. Eligibility Criteria (Answer the questions by circling Yes or No.)

1) It is confirmed as primary chordoma, chondrosarcoma or meningioma of the basal skull pathologically or by diagnostic imaging. ***Yes*** ***No***

2) The maximum diameter of the tumor is 10cm or less, and the case is stage N0M0. ***Yes*** ***No***

3) There is a measurable lesion at the start of particle radiation therapy. ***Yes*** ***No***

4) Performance Status (PS) is 0, 1, or 2. ***Yes*** ***No***

5) Patient is able to maintain the posture required at the time of irradiation (in supine or sedentary position for approximately 30 minutes). ***Yes*** ***No***

6) The functions of the major organs are maintained. ***Yes*** ***No***

7) The location that receives particle beam radiation therapy has not been treated with radiation therapy in the past. ***Yes*** ***No***

8) There is no active infection in the region. ***Yes*** ***No***

9) There are no active double cancers or severe complications. ***Yes*** ***No***

2.Tests Required to Start Particle Beam Radiation Therapy

List of Required Tests	Date Performed	Status
Biopsy (prepared slide)	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Pathological diagnostic report	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Hematological test and biochemical test	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Head and neck MRI	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Neck to upper mediastinum CT scan	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Bone scintigram	MM/DD/YYYY	□ Performed □ Not Performed □ Planned

* Scans and blood test should be performed within 8 weeks prior to particle beam radiation therapy.

3. Checklist Confirmation Please mark X in the box □ to the applicable description.

A. Eligibility criteria are all Yes and all of the required tests have been performed. □

B. Eligibility criteria are all Yes and some of the required tests have been performed. □

C. Neither of the above. □

Contact:
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http://www.hibmc.shingu.hyogo.jp/ Fax: Japan 0791-58-2600