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

Peripheral Lung Cancer (Stage I) Check Items/Test Items

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

1) It is primary non-small cell lung cancer diagnosed pathologically including cytological malignancy. ***Yes*** ***No***

2) It is peripheral lung cancer occurring in the periphery farther than subsegmental bronchi. ***Yes*** ***No***

3) The tumor is stage T1-2N0M0 (UICC2002) and the maximum diameter is 5cm or less. ***Yes*** ***No***

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

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

6) The patient is able to maintain the posture required at the time of irradiation (in supine position for approximately 30 minutes). ***Yes*** ***No***

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

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

9) There is no complication of severe interstitial pneumonia. ***Yes*** ***No***

10) There is no active infection in the location that receives particle beam radiation therapy. ***Yes*** ***No***

11) 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
Tumor marker	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Brain MRI	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Chest to upper abdominal region contrast-enhanced CT	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Whole body PET-CT	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Spirometry	MM/DD/YYYY	□ Performed □ Not Performed □ Planned

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

3. Confirmation Please mark X in the box □ for the description that best applies.

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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