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
  Name of the Hospital/Clinic: ________________________________
  Address: ________________________________________________

- 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  Tel.: Japan 0791-58-0100 (Main)
http://www.hibmc.shingu.hyogo.jp/  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

Mediastinal Tumor Check Items/Test Items

1. Eligibility Criteria  (Answer the questions by circling Yes or No.)
   1) Pathologically or by imaging diagnosis, the mediastinal tumor was diagnosed as malignant. Yes No
   2) It is a solitary tumor with a max. diameter of 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) If chemotherapy is used, it will be stopped before starting particle beam radiation therapy Yes No
   5) Performance status (PS) is 0, 1, or 2. Yes No
   6) It is possible 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 before. 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

<table>
<thead>
<tr>
<th>List of Required Tests</th>
<th>Date Performed</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biopsy (prepared slide)</td>
<td>MM/DD/YYYY</td>
<td>□ Performed □ Not Performed □ Planned</td>
</tr>
<tr>
<td>Pathological diagnostic report</td>
<td>MM/DD/YYYY</td>
<td>□ Performed □ Not Performed □ Planned</td>
</tr>
<tr>
<td>Hematological test and biochemical test</td>
<td>MM/DD/YYYY</td>
<td>□ Performed □ Not Performed □ Planned</td>
</tr>
<tr>
<td>Tumor marker</td>
<td>MM/DD/YYYY</td>
<td>□ Performed □ Not Performed □ Planned</td>
</tr>
<tr>
<td>Brain MRI</td>
<td>MM/DD/YYYY</td>
<td>□ Performed □ Not Performed □ Planned</td>
</tr>
<tr>
<td>Chest to upper abdominal contrast-enhanced CT</td>
<td>MM/DD/YYYY</td>
<td>□ Performed □ Not Performed □ Planned</td>
</tr>
<tr>
<td>Whole body FDG-PET</td>
<td>MM/DD/YYYY</td>
<td>□ Performed □ Not Performed □ Planned</td>
</tr>
<tr>
<td>Spirometry</td>
<td>MM/DD/YYYY</td>
<td>□ Performed □ Not Performed □ Planned</td>
</tr>
</tbody>
</table>

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

3. Confirmation of the Information  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. □