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

Small-sized Liver Cancer Check Items/Test Items

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

1) Pathologically, it is confirmed as a primary liver cancer (hepatocellular carcinoma). *Yes* *No*
   Or more than one of the following three clinical diagnosis standards is met. *Yes* *No*
   - Hepatitis ____ (C or B)
   - AFP _____ ng/mL (10 or more) PIVKA-II _____ mAU/mL (40 or more)
   - Abdominal dynamic CT or hepatic artery angiography shows a transient stain in early phase and a low concentration in late phase (60 seconds or later).

2) The Stage is T1-T3N0M0 (UICC2002) and there is no direct tumor invasion to hepatic portal vein or inferior vena cava. *Yes* *No*

3) The tumor is solitary with the maximum diameter of 5cm. If the patient has had a tumor in the liver before, the previous lesions are controlled. *Yes* *No*

4) The tumor is at least 2cm from the digestive tract. *Yes* *No*

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

6) Performance status (PS) is 0, 1, or 2. *Yes* *No*

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

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

9) Child-Pugh classification is A (5 to 6 points) or B (7 to 9 points). *Yes* *No*

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

11) There is no RC-sign positive gastroesophageal varicosity *Yes* *No*

12) There is no active infection other than hepatitis in the location that receives particle beam radiation therapy. *Yes* *No*

13) 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
Hematological and biochemical tests (including PT activation and ICG R-15)	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Tumor marker (AFP, PIVKA-II, CEA)	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Chest CT scan	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Abdominal dynamic CT scan	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Bone scintigram	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Endoscopy for the esophagus and upper digestive tract	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 of the Information Please mark X in the box □ next 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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