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

Kidney Cancer Check Items/Test Items

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

1) It is confirmed as a kidney cancer pathologically or by diagnostic imaging. ***Yes*** ***No***

2) The maximum diameter of the tumor is 10cm and it is in N0M0 stage. ***Yes*** ***No***

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

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

5) If chemotherapy has been used, it will be stopped before 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) The definitive surgery is difficult or the patient refuses a surgery. ***Yes*** ***No***

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

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

12) 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 diagnosis report	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Hematological test, biochemical test, and urinalysis	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Chest CT	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Abdominal contrast-enhanced CT	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. 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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