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

Prostate Cancer Check Items/Test Items

1. Patient Condition Summary (Enter names/values in blanks and answer questions by circling.)

First exam (before endocrine therapy) max. PSA value _____ng/ml (Date: MM/DD/YYYY)

Tumor location at first exam: (Right, left, both sides) as diagnosed by (MRI, ultrasonography, palpation)

Capsular penetration? (Yes No) Seminal vesicle invasion? (Yes No)

Biopsy result (number of positive cores) Right_____/_____, Left_____/_____

Gleason score _____+_____

Endocrine therapy performed (Yes No) How long until now? _____ months

Name of drug: _____ Therapy period from MM/DD/YYYY to MM/DD/YYYY

Name of drug: _____ Therapy period from MM/DD/YYYY to MM/DD/YYYY

Recent PSA: _____ng/ml (MM/DD/YYYY) PSA failure: (Yes No)

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

1) It is pathologically or clinically confirmed as a prostate cancer. ***Yes*** ***No***

2) The systemic exam performed at the time of diagnosis confirms that there is no lymph node metastasis or no distant metastasis. ***Yes*** ***No***

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

4) 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***

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

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

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

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

9) There is no severe diabetes (HbA1c 8.0% or higher or insulin 30 units/day or higher). ***Yes*** ***No***

3. Tests Required to Start Particle Beam Radiation Therapy

List of Required Tests	Date of Confirmed Diagnosis (Required)	Date of the Most Recent Test	Status
Systematic needle biopsy (prepared slide)	MM/DD/YYYY	N/A	□ Performed □ Not Performed □ Planned
Pathological diagnosis report	MM/DD/YYYY	N/A	□ Performed □ Not Performed □ Planned
Hematological and biochemical tests (including HbA1c)	MM/DD/YYYY	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Tumor marker (PSA)	MM/DD/YYYY	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Prostate MRI	MM/DD/YYYY	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Abdominal - pelvis contrast-enhanced CT	MM/DD/YYYY	N/A	□ Performed □ Not Performed □ Planned
Bone scintigram	MM/DD/YYYY	N/A	□ Performed □ Not Performed □ Planned

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