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

Metastatic Tumor Check Items/Test Items

1. Summary of Disease Condition

Region of metastatic tumor (area) :_____ **Max. diameter :**_____**cm**

Pathology of metastatic tumor: _____ **Primary region:**_____

Previous treatment period (including primary focus): _____MMDDYYYY（**region**_____ ）

Previous treatment method _____

Disease-free interval before the current recurrence ____**months**

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

1) It is a solitary tumor diagnosed pathologically or clinically as metastasis of a malignant tumor. ***Yes*** ***No***
2) There is no active malignant lesion other than the metastatic tumor to be treated. ***Yes*** ***No***
3) The metastatic tumor and the intestine are at least 2 cm apart. ***Yes*** ***No***
4) There is a measurable lesion at the start of particle radiation therapy. ***Yes*** ***No***
5) Performance Status (PS) is 0, 1, and 2. ***Yes*** ***No***
6) 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 patient understands that there is a possibility of systemic metastases and he/she has a poor prognosis. ***Yes*** ***No***
9) The location that receives particle beam radiation therapy has not been treated with radiation therapy in the past. ***Yes*** ***No***
10) There is no active infection in the location that receives particle beam radiation therapy. ***Yes*** ***No***

3.Tests Required to Start Particle Beam Radiation Therapy

Test Check List	Date Performed	Status
Metastatic tumor biopsy (prepared slide)	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Metastatic tumor pathological diagnosis report	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Metastatic tumor region CT	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Metastatic tumor region MRI	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Whole body PET-CT	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Bone scintigram	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Brain MRI	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Imaging test which denies recurrence in the primary region		
Chest CT	MM/DD/YYYY	□ Performed □ Not Performed □ Planned
Abdomen to pelvis CT	MM/DD/YYYY	□ Performed □ Not Performed □ Planned

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

Contact:
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