

PATIENT INFORMATION

**indicates mandatory fields*

*TLC unit no. (if known)

*Title *DOB (dd/mm/yyyy)

*Surname

*Forename(s)

*Sex at birth M F OP IP: Room

Diagnosis

Tx site

Consented for RT? Previous RT (including Molecular RT)? Y N

BED calc? Indicate OAR:

Additional clinical info/ Prv RT:

Payment method Insurance Embassy Self-Pay

Payment provider

Patient's tel no.

*Patient's email

*Patient's address

Mobility:

Additional support needs:

Pacemaker ICD - Must be documented on Consent

Concurrent chemo

Discussed at MDT

Justification required if not discussed at MDT/no MDT records.

PLANNING CT

Consultant attending CT

Preferred CT date

Preferred volume date

Preferred RT start date

Contrast

- No contrast
- IV
- Oral
- Other

Risk will be assessed by radiographer as per PGD.

Positioning

- Body: Supine Prone
- Arms: Up On chest Up By side
- Neck: Extended Flexed Neutral

Immobilisation

- Shell Mouthbite

Dental assessment required Yes No

Date

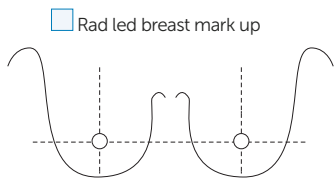
Please inform Planning of cover if unavailable during Tx period.

Motion management: FB DIBH ITV Additional info/justification if N/A

TREATMENT PLANNING

- VMAT/IMRT 3D VSim Clinical Mark up Linac STX Cyberknife

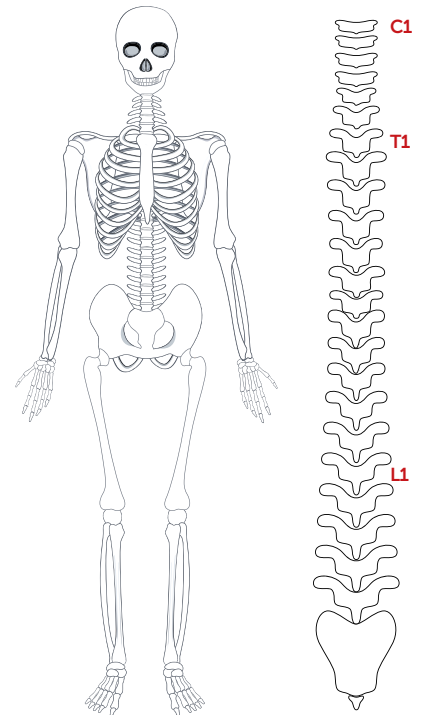
Ph1/Site	Ph2/Site
Gy/# <input type="checkbox"/> Alternate days?	Gy/#
Px depth in cm/MPD	Px depth in cm/MPD
Bolus? (cm)	Bolus? (cm)



- Rad led palliative localisation *
- * MUST be completed by 3rd #**
- Rad led instructions:

Rad led Energy Px:

- 6MV (dmax 1.5cm)
- 10MV (dmax 2.5cm)



IMAGING AND INTERVENTIONAL

- Image fusion External imaging requested?

New or existing imaging for radiotherapy planning: New Existing Site/date:

Additional notes:

- Fiducial markers Rectal Spacer

Referrer/practitioner's signature Print Date