

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	<input type="checkbox"/> Performed <input type="checkbox"/> Not Performed <input type="checkbox"/> Planned
Pathological diagnosis report	MM/DD/YYYY	N/A	<input type="checkbox"/> Performed <input type="checkbox"/> Not Performed <input type="checkbox"/> Planned
Hematological and biochemical tests (including HbA1c)	MM/DD/YYYY	MM/DD/YYYY	<input type="checkbox"/> Performed <input type="checkbox"/> Not Performed <input type="checkbox"/> Planned
Tumor marker (PSA)	MM/DD/YYYY	MM/DD/YYYY	<input type="checkbox"/> Performed <input type="checkbox"/> Not Performed <input type="checkbox"/> Planned
Prostate MRI	MM/DD/YYYY	MM/DD/YYYY	<input type="checkbox"/> Performed <input type="checkbox"/> Not Performed <input type="checkbox"/> Planned
Abdominal - pelvis contrast-enhanced CT	MM/DD/YYYY	N/A	<input type="checkbox"/> Performed <input type="checkbox"/> Not Performed <input type="checkbox"/> Planned
Bone scintigram	MM/DD/YYYY	N/A	<input type="checkbox"/> Performed <input type="checkbox"/> Not Performed <input type="checkbox"/> Planned

Contact:

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