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| Patient Name | <Full Name> |
| Patient ID1 (CR Number) | <Patient Id 1> |
| Date of Birth | <Date of Birth> |

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| --- | --- | --- | --- |
| Diagnosis: <Diagnosis> | | | |
| Radiation Oncologist:<Primary Care Physician - Name (Default)> | | | |
|  | | | |
| **Patient** | | | |
|  |  | | Verify patient’s identification using Date of Birth |
|  |  | | Confirm: **address, phone number or other contact number** |
|  |  | | **Check pregnancy status if female between 10 – 55 years** |
|  |  | | Does patient have a or  Yes 🡺  **Pacemaker** 🡺  **Referral made & Physicist notified**  **Implantable Cardiac Device (ICD)** 🡺  **Referral made & Physicist notified**  No |
|  |  | | Verify with patient in regard of hotel accommodation and any assistance in transportation |
| **Treatment** | | | |
|  |  | Identify patient’s past experience with radiation treatment | |
|  |  | Discuss number of treatments prescribed, check-in system, appointment requests and/ or changes | |
|  |  | Disrobing, moving, touching and positioning patient, instruct patient not to move | |
|  |  | Explain procedure to patient and answer any questions | |
|  |  | CCTV monitoring and intercom during treatment | |
|  |  | Discuss the pre and post monitoring of the patient by the Physicist. | |
|  |  | Discuss the imaging with the C-Arm | |
|  |  | Discuss side effects using the consent form and give appropriate symptom control information pamphlet | |
|  |  | Discuss skin care guidelines if necessary | |
|  |  | Discuss review process and availability of R.N. if required | |
|  |  | Discuss support systems (i.e. Dietitian, social worker and on-call physician, etc) | |
|  |  | Discuss length of daily treatment and programming of machine | |
|  |  | Discuss post treatment care i.e. vaginal dilators | |
|  |  | Digital photograph taken and uploaded into ARIA | |
|  |  | Consent complete and uploaded into ARIA | |
|  | | | |

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| **Family present:** |

**Comments:**