|  |  |
| --- | --- |
| Patient Name | <Full Name> |
| CR Number | <Patient Id 1> |
| Date of Birth | <Date of Birth> |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Diagnosis: <Diagnosis> | | | | | | | | | | | | | | | |
| Radiation Oncologist: <Primary Care Physician-Name (Default)> | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Patient** | | | | | | | | | | | | | | | |
|  |  | Confirm: **Date of Birth, address, phone number or other contact number 🡺** | | | | | | | | | | | | | |
|  |  | **Check pregnancy status if female between 10 – 55 years** | | | | | | | | | | | | | |
|  |  | Digital photograph taken and uploaded into ARIA | | | | | | | | | | | | | |
|  |  | Does patient have a or  Yes 🡺  **Pacemaker** 🡺  **Referral made & Physicist notified**  **Implantable Cardiac Device (ICD)** 🡺  **Referral made & Physicist notified**  No | | | | | | | | | | | | | |
|  |  | **Hotel Reservation**  Yes  No | | | | | Accommodation application sent to RT Manager | | | **Initial** |  | | | | |
|  |  |  | | | | |  | | | **Date** |  | | | **(DD/MMM/YYYY)** | |
| **COVID-19 Testing for Asymptomatic Patient** | | | | | | | | | | | | | | | |
|  |  | **Discuss with patient about complete the COVID-19 test prior to first radiation treatment visit**  Agreed  Declined | | | | | | | | | | | | | |
| **Planning Process** | | | | | | | | | | | | | | | |
|  |  | Moving, touching and positioning patient, instruct patient not to move | | | | | | | | | | | | | |
|  |  | Use of x-rays in CT simulator | | | | | | | | | | | | | |
|  |  | Use of treatment related accessories (MEDTEC breast board, MEDTEC belly board, Thermoplast, etc) | | | | | | | | | | | | | |
|  |  | Tattooing procedure including consent | | | | | | | | | | | | | |
|  |  | Use of contrast media and verify patient with any allergy | | | | | | | | | | | | | |
|  |  | **Does patient have a Freestyle Libre Flash Glucose Monitoring with a skin mounted sensor**  Yes 🡺 Remove sensor prior to CT scan if sensor falls in the scan region | | | | | | | | | | | | | |
|  |  | Smoking instructions given to patient | | | | | | | | | | | | | |
|  |  | Special Instructions given to patient. (i.e. **Full bladder, Empty bladder,** **Empty rectum, DIBH, 4DCT**) | | | | | | | | | | | | | |
| **Consent** | | | | | | | | | | | | | | | |
|  |  | Consent for treatment | | | | | | | | | | | | | |
|  |  | Consent for IV contrast completed | | | | | | | | | | | | | |
| **Booking** | | | | | | | | | | | | | | | |
|  |  | **Treatment appointments** | | | | | | | | | | | | | |
|  |  | Pre-booked patient given start date and time | | | | | | | | | | | | | |
|  |  | Date : |  | **(DD/MMM/YYYY)** |  | Time: | |  | (HH:MM) – 24 Hours Format | | |  | Treatment Unit: | |  |
|  |  | Discuss RT and chemotherapy bookings (concurrent or sequential) (**Record Last Chemo Date**) | | | | | | | | | | | | | |
|  |  | Date : |  | **(DD/MMM/YYYY)** |  | | | | | | | | | | |
|  |  | Inform patient that they will be called with 1st appointment for treatment | | | | | | | | | | | | | |

**Comments:**