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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)> |

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| **Treatment Intent** |  | | | | |
| **Treatment Site** |  | | | | |
| **Radiation Quality (KV) / HVL** |  | | | | |
| **Applicator** |  | | | | |
| **Cut Out Size (cm)** |  | | | | |
|  | **(Please specify dimesions):** |  | **X** |  | **cm2 as per diagram** |
| **Dose Fractionation (cGy / Frs)** | **1500 cGy / 5Frs, 6 to 12 weeks gap then 1500 cGy / 5Frs** | | | | |
| **Prescription Point** | **Skin surface at cone end** | | | | |
| **Stand-off (mm)** | **(Please specify standoff in mm):** | | | | |
| **Stand-off Correction** |  | | | | |

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| **Call for Day 1 Setup** | **Others (Please specify):** |
| **Weekly Review Clinic** |  |
| **Follow Up** | **Others (Please specify):** |
| **Technical Notes & Orders** **For Radiation Therapy Team** (e.g. Patient requires pre-treatment medication) | |

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