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| Description: Description: KRCCLogo Black | **Superficial / Orthovoltage Treatment Prescription** |
| 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** |  |

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| **Treatment Site** |  |

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| **Radiation Quality (KV) / HVL** |  |
| **Applicator** |  |
| **Cut Out Size (cm)** |  |
| **Dose Fractionation (cGy / Frs)** | **Others (Please specify):** |
| **Prescription Point** | **Others (Please specify):** |
| **Stand-off (mm)** | **(Please specify standoff in mm):** |
| **Stand-off Correction** |  |

|  |  |
| --- | --- |
| **Bolus** | **Others (Please specify):** |
| **Shielding** | **Eye Shields :**  **Nasal Shields :**  **Lip Shield :**  **Posterior Ear Shields :**  **Others (Please specify):** |
| **Call for Day 1 Setup** | **Others (Please specify):** |
| **Follow Up** | **Others (Please specify):** |
| **Technical Notes & Orders** **For Radiation Therapy Team** (e.g. Patient requires pre-treatment medication) | | |

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