

Hosp No. :	HKID No.:
Case No. :	
Name :	
DOB :	M / F
Adm Date :	
Contact No.:	

Radiotherapy Planning / CT Simulation Request Form

Radiotherapy and Oncology Department

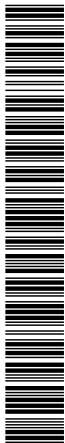
Patient Name:		HKID / Passport No:	
<i>For Private Patient only:</i>	<i>Mobile:</i>	<i>Email:</i>	
Diagnosis:			
Pre-RT assessment:	<input type="checkbox"/> Patient is pregnant <input type="checkbox"/> Hepatitis / _____ <input type="checkbox"/> Dental referral is given <input type="checkbox"/> Patient is implanted with Cardiac Implantable Electronic Devices (e.g. Pacemaker, ICD) (Please refer patient for Cardiologist consultation) <input type="checkbox"/> Patient received RT treatment previously in _____ (hospital) _____ (year) (Please sign 2nd Course RT consent if applicable)		

Radiotherapy Planning Detail:

Rx Site:	
Moulding / Immobilization request:	<input type="checkbox"/> Follow department Routine Set-up <input type="checkbox"/> Please specify: _____
Treatment Planning:	<input type="checkbox"/> CT Plan <input type="checkbox"/> Manual Plan (not involve Planning CT scan)
CT Planning Request:	
Planning CT scan region:	
Planning CT slice thickness:	<input type="checkbox"/> 0.1cm <input type="checkbox"/> 0.2cm <input type="checkbox"/> 0.3cm <input type="checkbox"/> Others: _____ cm
Planning CT Simulation:	<input type="checkbox"/> Plain <input type="checkbox"/> IV Contrast (Please sign Contrast CT Consent and complete the following 'Assessment for IV Contrast Injection') <input type="checkbox"/> Oral Contrast

Assessment for IV Contrast Injection:

Body Weight (Kg)	_____	LMP (if applicable)	_____
Has previously undergone examinations requiring IV contrast medium injection	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Remarks:</i> * <input type="checkbox"/> Pre-medication is prescribed for contrast CT planning * <input type="checkbox"/> No need for Pre-medication
History of reaction to previous contrast injection	<input type="checkbox"/> No	<input type="checkbox"/> Yes *	
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Other allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes *	
Heart disease / Hypertension	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Renal Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Diabetes Mellitus (on Metformin)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<i>For Patient age > 60 or has history of renal disease / DM / Hypertension / receive Chemotherapy <3 months</i>			
Serum Creatinine:	_____ μmol/L	on _____ (within 60 days prior to the exam)	eGFR: _____ ml/min/1.73m ²



Hosp No. :	HKID No.:
Case No. :	
Name :	
DOB :	M / F
Adm Date :	
Contact No. :	

Radiotherapy Planning / CT Simulation Request Form

Radiotherapy and Oncology Department

Special scanning request:	<input type="checkbox"/> 4DCT (10 phases) <input type="checkbox"/> Breath-hold (inspiration) <input type="checkbox"/> Breath-hold (expiration)
	<input type="checkbox"/> Empty Stomach (Fast 4hrs before CT / Rx)
	<input type="checkbox"/> Empty Bladder <input type="checkbox"/> Full bladder
	<input type="checkbox"/> Empty Rectum (<input type="checkbox"/> prescribed Senokot or Dulcolax for both CT and Rx)
	<input type="checkbox"/> Marker at <input type="checkbox"/> Introitus <input type="checkbox"/> Anus <input type="checkbox"/> Scar x _____ <input type="checkbox"/> Others: _____
<input type="checkbox"/> Bolus area: <input type="checkbox"/> 0.5cm <input type="checkbox"/> 1cm thickness with _____cm margin from scar/_____ / cover whole field	
Planning CT Image fusion with:	<input type="checkbox"/> MRI <input type="checkbox"/> PET CT <input type="checkbox"/> CT Date: Date: Date:
	**Please remind patient to bring back Dx images CD Rom for image registration if available.
Presence of referring doctor on CT Scanning date:	<input type="checkbox"/> No <input type="checkbox"/> Yes, consultation → <input type="checkbox"/> before Planning procedure <input type="checkbox"/> after Planning procedure

Tentative Radiotherapy Treatment Detail:

Rx Technique:	<input type="checkbox"/> VMAT / IMRT <input type="checkbox"/> 3D conformal <input type="checkbox"/> Electron <input type="checkbox"/> Simple (Single field/ Opp fields) <input type="checkbox"/> Frameless SRS / SRT <input type="checkbox"/> Frame-based SRS <input type="checkbox"/> SBRT
Motion Control:	<input type="checkbox"/> Gating <input type="checkbox"/> Breath-hold (inspiration) <input type="checkbox"/> Breath-hold (expiration)
Rx verification:	<input type="checkbox"/> Daily kV / MV <input type="checkbox"/> Weekly CBCT <input type="checkbox"/> CBCT for each fraction <input type="checkbox"/> Others
<input type="checkbox"/> Concurrent Chemo RT	<input type="checkbox"/> On _____ <input type="checkbox"/> To be confirmed
<input type="checkbox"/> Patient will admit in GHK	<input type="checkbox"/> On _____ <input type="checkbox"/> To be confirmed
Tentative Rx date:	<input type="checkbox"/> Within / <input type="checkbox"/> After _____ <input type="checkbox"/> Days / <input type="checkbox"/> Weeks <input type="checkbox"/> Within the week of _____ <input type="checkbox"/> Please specify : _____
Preliminary Rx scheme:	Tentative dose: _____ Gy in _____ fractions. <input type="checkbox"/> Electron Boost for _____ fractions
Remarks:	

Signature of Referring Doctor: _____

Name in BLOCK LETTER / Chop: _____

Date: _____

