Gleneagles HONG KONG 港怡醫院

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:	
For Private Patient only:	*Mobile:*	*Email:*	
Diagnosis:			
Pre-RT assessment:	❑ Patient is pregnant ❑ Hepatitis /_____ ❑ Dental referral is given ❑ Patient is implanted with Cardiac Implantable Electronic Devices (e.g. Pacemaker, ICD) ***(Please refer patient for Cardiologist consultation)*** ❑ Patient received RT treatment previously in _____(hospital)_____(year) (***Please sign 2nd Course RT consent if applicable***)		

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

Assessment for IV Contrast Injection:

Body Weight (Kg) _____ LMP (if applicable) _____

Has previously undergone examinations requiring IV contrast medium injection	❑ No	❑ Yes	*Remarks:* * ❑ *Pre-medication is prescribed for contrast CT planning* * ❑ *No need for Pre-medication*
History of reaction to previous contrast injection	❑ No	❑ Yes*	
Asthma	❑ No	❑ Yes	
Other allergies	❑ No	❑ Yes*	
Heart disease / Hypertension	❑ No	❑ Yes	
Renal Disease	❑ No	❑ Yes	
Diabetes Mellitus *(on Metformin)*	❑ No	❑ Yes	

For Patient age > 60 or has history of renal disease / DM / Hypertension / receive Chemotherapy <3 months

Serum Creatinine: _____ µmol/L on _____ (within 60 days prior to the exam)

eGFR: _____ml/min/1.73m²

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

Tentative Radiotherapy Treatment Detail:

Rx Technique:	❑ VMAT / IMRT	❑ 3D conformal	❑ Electron	❑ Simple (Single field/ Opp fields)
	❑ Frameless SRS / SRT	❑ Frame-based SRS	❑ SBRT	
Motion Control:	❑ Gating	❑ Breath-hold (inspiration)	❑ Breath-hold (expiration)	
Rx verification:	❑ Daily kV / MV	❑ Weekly CBCT	❑ CBCT for each fraction	
	❑ Others			

❑ Concurrent Chemo RT	❑ On _____	❑ To be confirmed
❑ Patient will admit in GHK	❑ On _____	❑ To be confirmed
Tentative Rx date:	❑ Within / ❑ After _____ ❑ Days / ❑ Weeks ❑ Within the week of _____ ❑ Please specify : _____	
Preliminary Rx scheme:	Tentative dose: _____ Gy in _____ fractions. ❑ Electron Boost for _____ fractions	
Remarks:		

Signature of Referring Doctor: _____

Name in BLOCK LETTER / Chop: _____

Date: _____