RADIOTHERAPY REFERRAL FORM (V11)

THE LONDON CLINIC

PATIENT INFORMATION

TLC unit nos. L

Title | DOB

Surname

Forename(s)

Gender ☐M ☐F | ☐IP ☐OP | Room

Payment method ☐Insurance ☐Embassy ☐Self-pay

Payment provider

Patient's tel no.

Patient's email

Patient's address

Diagnosis:

Treatment site:

☐ Consented for RT)

☐Walking ☐Wheelchair ☐Bed ☐Interpreter(Language)

☐Pacemaker ☐ICD ☐Pacemaker/ICD documented on Consent?

☐Clinical Trial Trial name)

☐Concurrent chemo Chemo Regime)

Previous RT(including molecular RT) ☐ Hospital ☐N

Discussed at MDT? ☐ Hospital

Must provide justification if not discussed at MDT/no MDT records

Additional clinical information:

PLANNING CT

☐ Consultant attending CT

Preferred CT date

Preferred volume date

Preferred RT start date

Contrast

☐No contrast

☐IV Omnipaque300 as per protocol

☐Oral Omnipaque300 as per protocol

☐Oral Gastrografin as per protocol

Others

If known kidney disease Visipaque270as per protocol Risk will be assessed by radiographer.

Positioning

☐Supine ☐Prone

Arms: ☐Up ☐On chest ☐By side

Neck: ☐Extended ☐Flexed ☐Neutral

Immobilisation

☐Shell ☐Mouthbite

Dental assessment required? Yes ☐ No ☐

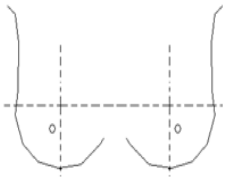
Date for dental assessment /other

Please inform Planning if you will be unavailable during Tx period and to nominate Clinical Oncologist cover

Motion management

	Treat in FB	Treat in BH
Breast/Chestwall	☐ FB	☐ DIBH
Abdomen/Chest	☐ ITV	☐ IBH ☐ EEBH
Not required (Reasons)		

☐ **Rad led breast mark up**



☐ **Rad led palliative localisation** ★

★MUST be completed by 1st 3# or by( )

Rad led instruction

Rad led instruction

TREATMENT PLANNING

☐VMAT/IMRT ☐3D ☐VSim ☐Cyberknife

Ph1/Site	Ph2/Site
Gy/#	Gy/#
Depth in cm/MPD	Depth in cm/MPD
☐6MV ☐10MV ☐6MeV ☐9MeV ☐12MeV ☐16MeV ☐20MeV	☐6MV ☐10MV ☐6MeV ☐9MeV ☐12MeV ☐16MeV ☐20MeV

Bolus (cm #)

☐ Image fusion ☐ Images requested if not at TLC?

EXISTING imaging for radiotherapy planning:

Details of existing images required for planning e.g. location, modality, pre/post op, scan date

Additional notes:

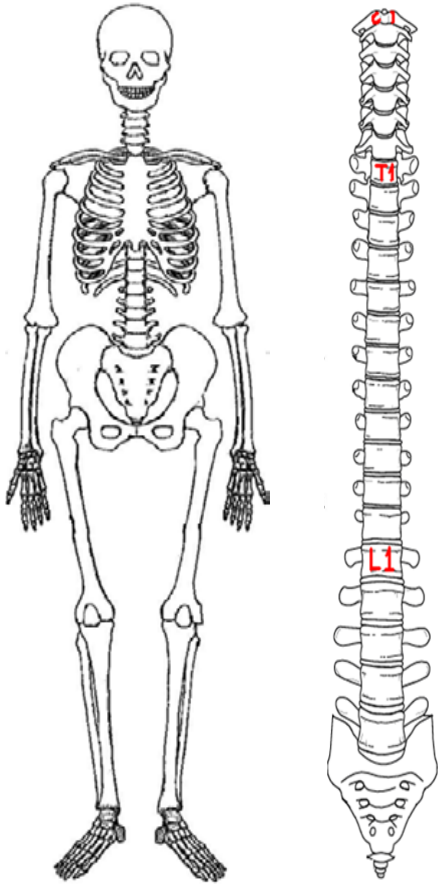
☐ Fiducials for radiotherapy planning

☐ Spacer for Linac RT

☐ Spacer Fiducials for Cyberknife

☐ NEW imaging request:

Please complete separate Radiology IMAGING REQUEST form for new imaging e.g. MRI, PET, Angio required for radiotherapy planning, use RT immobilisation and flat couch whenever possible.

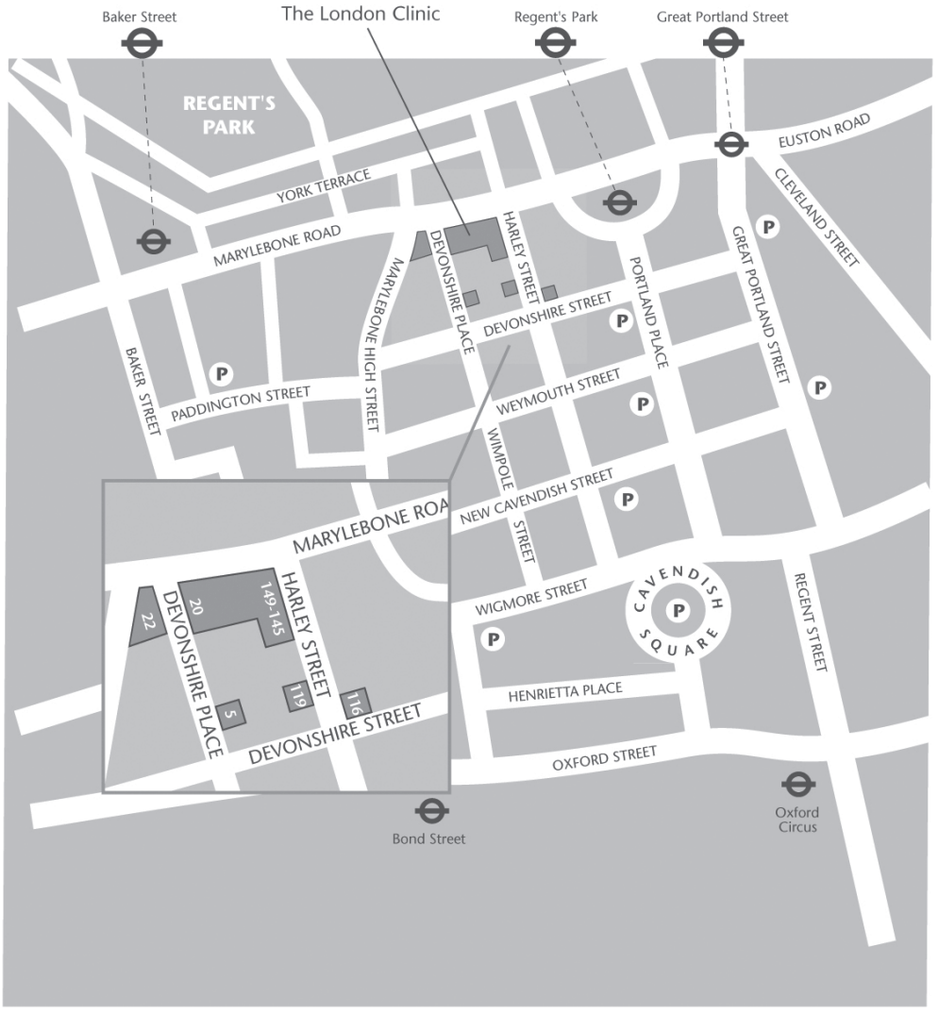


Referrer/Practitioner's Signature Signature (PRINT) **Date**

Radiotherapy Department

Tel: 020 7616 7759 Fax: 020 7616 7792 or 020 7034 6290 Email: radiotherapybookings@thelondonclinic.co.uk

www.thelondonclinic.co.uk



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