Form for Remote-Visit Palliative Radiation Therapy **Remote-Visit Date (d/m/y): ____/____/_____**

Patient Name/Surname: _____ Gender: M□ F□ DOB (d/m/y): ____/____/_____

RT Chart ID (If available): _____

Radiation Oncologist in charge: _____

Patient from: □ Ward: _____ □ D.H. □ Home □ HomeCare/Hospice □ Other _____

Referring Physician: Specialist _____ GP_____

Autonomous Deambulation: □ Yes □Wheelchair □Bed Ambulance: □ Yes □ No

ECOG - KPS Score: _____ PPS Score [(1)]: _____%

Primary Cancer Site:

□ Breast □ Lung □ Prostate □ Upper/ Lower GI: _____ □ Kidney □ Gyn

□ Head&Neck □ Multiple Myeloma □ Melanoma □ Other: _____

Last Imaging Available: □ MRI □ CT-Scan □ PET Scan □ Other Date: d____/m____/y_____

Systemic Therapy Ongoing: □ No □ Yes

(if "Y" □ Chemotherapy □ Hormone-therapy □ Immunotherapy; Last infusion Date: d____/m____/y_____)

Reason for Radiation Therapy Evaluation:

Pain: NRS 0-10: _____; □ Mild (1-3) □ Moderate (4-7) □ Severe (8-10)

□ Bone (□ Spinal □ Not Spinal) SINS Score [(2)]: _____

□ Neuropathic PMI (Pain Management Index) Value: _____;

□ Other_____ Suspect Breakthrough Pain □

Fracture: □ Pathological □ Impeding

□ Post Surgery Setting (if Y: Date: ___/___/____)

(if Y, please specify: □ Spinal □ Not Spinal □ Mini-invasive)

Ongoing Pain Therapy: _____

_____

_____

Bleeding

□ GI □ GU □ Hemoptysis □ Pelvic

Hb_____ (Date d___/m____/y_____)

Transfusion? □ No □ Yes; IF Y, Date: d____/m____/y____

1: Anderson F et al.; J Palliat Care. 1996 Spring;12(1):5-11; PMID: 8857241
2: Shandy F. et al; Global Spine J. 2017 Dec; 7(8): 744–748; doi: 10.1177/2192568217697691
3: Timothy TR, Clin Orthop Relat Res. 2017 May; 475(5): 1499–1504; doi: 10.1007/s11999-016-5133-4
4: Indicate Selected Prognostic for the Center_____

CNS:

□ Impending Cord Compression

□ Cauda Equina Syndrome

□ Symptomatic Cord compression: Since how long? _____ ASIA SCORE [3]: _____

□ Brain Metastases: n°_____ Symptoms: □ No □ Yes (Description:_____)

Anti-edema Therapy: □ No □ Yes (□ Steroid Therapy □ Mannitol)

Symptomatic Lymph-Nodes: □ No □ Yes

□ Pelvic nodes

□ Neck Nodes

□ Other_____

Thoracic:

□ Mediastinal Syndrome

□ Dyspnea □ Dysphagia

□ Other:_____

Subcutaneous Nodes: Symptomatic: □ No □ Yes ; District_____

Prognostic Score [4] Value/Result: _____

Radiation Therapy Detalis

Previous RT: □ No □ Yes District_____ If Y, is this retreatment? □ No □ Yes ;

Available Previous RT Details: □ No □ Yes ; Available Previous RT DICOM? □ No □ Yes □ To require

Accrued into Clinical Trial: □ No □ Yes (If Y, which one?_____)

Case Disposition:

□ Accepted □ Referred to Medical Oncologist □ Referred to Palliative Care □ Further investigation required

□ Referred to Pharmacologic Pain Therapy

□ Referred to Multidisciplinary Pain Management (Date (d/m/y): ____/____/_____)

□ Referred to Surgeon (Which specialty? _____)

□ Referred to Mini-invasive Therapy

□ No action □ Inappropriate referral □ Patient Asymptomatic □ Patient declined treatment

□ Palliative radiation site 1: _____

Dose (total)/Fraction: _____/_____

Date (d/m/y): ____/____/_____

□ Palliative radiation site 2: _____

Dose(total)/ Fraction: _____

Date (d/m/y): ____/____/_____

□ Palliative radiation site 3: _____

Dose (total)/ Fraction: _____

Date (d/m/y): ____/____/_____

Choice of Date: □ Clinic OR □ Patient

Outpatient Visit Scheduled: Date (d/m/y)____/_____/_____; Simulation associated □

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