(sending institution: please stamp here):

phone: (____________) ____________ - __________ extension please

patient label
name, date of birth, address

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Uniklinik Köln

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RADIOTHERAPY FORM RX

Trial: **AVD-Rev**

Case ID: **CRF ID:**

irradiation fields

SUPRADIAPHRAGMATIC

numbers: _______ / _______ / _______ / _______
(see graphic)

INFRADIAPHRAGMATIC

numbers: _______ / _______ / _______ / _______
(see graphic)

radiation quality phot. ☐ electr. ☐
radiation energy ☐☐ MeV
single dose ☐,☐☐ Gy
weekly dose ☐☐,☐☐ Gy
total dose ☐☐,☐☐ Gy
first irradiation day month year
last irradiation day month year

IF: ☐

residual lymphnodes: ☐

toxicity under radiotherapy grade 3 / 4?

☐ yes ☐ no

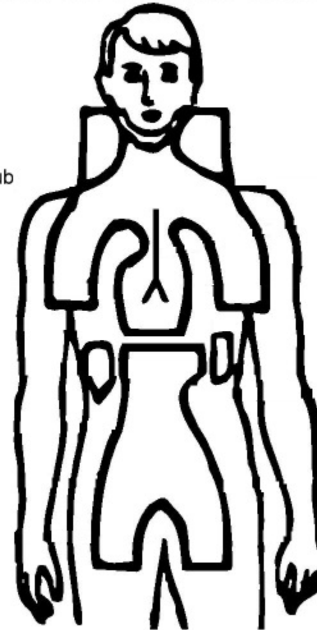
if yes, please specify as per CTC-score:

criterion	grade 3	grade 4
anemia		
leucopenia		
thrombopenia		
nausea / vomiting		
dysphagia		
mucous membranes		
heart		
respiratory tract		
larynx		
urogeniatal system		
nervous system		
skin, local/ RT field		
bleedings		
alopecia		
infection		

Please mark the RT fields in the graphic!

right:

1 Waldeyer's ring
3 upper cerv./ nuch./sub
5 cervical
7a supraclav.
7b infraclav.
9 axillary
11a upper mediastinum
12 lung hilum
17a liver hilum
17b coeliacal
18 mesenterial
22 iliacal
24 inguinal / femoral



left:

2 Waldeyer's ring
4 upper cerv./ nuch./subm.
6 cervical
8a supraclav.
8b infraclav.
10 axillary
11b lower mediastinum
13 lung hilum
19 spleen
20 spleen hilum
21 paraaortic
23 iliacal
25 inguinal/ femoral
26 bone

30 other (please specify): ______________________________

remarks:

day month year

____
Investigator signature