

REGISTRATION FOR SELECTIVE INTERNAL RADIO-THERAPY (SIRT)

Patient's name _____ Email address _____
Date of Birth (D|M|Y) _____ Residential address _____

Name of the referring physician _____
Phone _____
Fax _____

Diagnosis

We require the following documents from the patient for evaluation:

- Completed questionnaire (see appendix)
- Previous imaging (PET / CT, CT, MRI etc.) - Report and CD

In case no current imaging is available, this can of course be performed in our clinic.
If so, please provide a short feedback.



1. GENERAL INFORMATION

Patient's name _____

Date of Birth (D|M|Y) _____

Complete address _____

Patient speaks English

Yes

No

Patient speaks German

Yes

No

Patient speaks Russian

Yes

No

Primary Care physician

Name _____

Address _____

Mail _____

Oncologist nearby

Name _____

Address _____

Mail _____

NET-Center Oncologist

Name _____

Address _____

Mail _____

Ga-68 Receptor PET/CT has been performed

No

Yes

Date _____

Institution / City _____

2. ONCOLOGIC DIAGNOSIS AND CLINICAL COURSE OF DISEASE

Please provide information as completely as possible

Neuroendocrine Tumor	<input type="text"/>	Site of the Primary e.g. pancreas, midgut	<input type="text"/>
First Diagnosis established in (M Y)	<input type="text"/>	Histopathology detailed grading	<input type="text"/>
Immunohistochemistry Staining for Chromogranin A, Synaptophysin	<input type="text"/>	Tumor Proliferation Rate Ki-67 index	<input type="text"/>

Course of disease/summary of previous treatments

Please complete in chronological order (from / to)

Surgical Interventions

No
 Yes

Date
 PT
 Metastases

Biotherapy (octreotide, interferon etc.)

No
 Yes from to

Specify

Chemotherapy

No
 Yes from to

Molecular targeted therapy (everolimus, kinase inhibitors)

No
 Yes from to

Specify

Regional therapy (e.g. RFA, TACE, SIRT)

No
 Yes

Date
 Type

3. PAST MEDICAL HISTORY

(e.g. major surgery, infections, cardiovascular events etc.)

Renal diseases	No	Yes	
Diabetes	No	Yes	First diagnosis
Oral medication	No	Yes	
Insulin	No	Yes	
Hypertension	No	Yes	First diagnosis
Biophosphonate therapy	No	Yes	

4. CURRENT MEDICATION

List all your medications in detail and how often you are taking them per day.

Somatostatin analogs

Octreotide (e.g. Sandostatin LAR)	No	Yes
Lanreotide (e.g. Somatuline)	No	Yes
Other _____		
Dosing mg	_____	
Dosing interval (in weeks)	_____	
Last injection on (D M Y)	_____	
Subcutaneous dosing	_____ µg/day	last on (D M Y) _____ at (time) _____

5. CLINICAL SYMPTOMS

Height _____ cm

Weight _____ kg

weight loss
 weight gain
 constant

kg in months
 kg in months

Flush	no flushing (G0)	<1× per week (G1)	1–5× per week (G2)
	>1–5× per day (G3)	>5× perday / permanent (G4)	

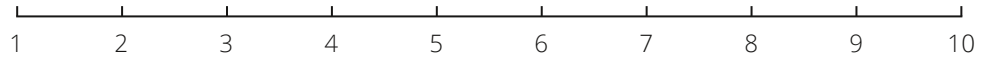
Diarrhea	normal consistency	3–5× per day (G1)	5–10× per day (G2)
Dyspnea	No	Yes	
Dyspnea upon exertion	No	Yes	
Edema	No	Yes (pretibial)	

Pain	No	Yes
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Major site of pain

VAS

0 = no pain
 10 = strongest pain



6. KARNOFSKY-INDEX

Karnofsky-Index _____ %

- | | |
|--|---|
| 100 % Normal, no complaints; no evidence of disease | 50 % Requires considerable assistance and frequent medical care |
| 90 % Able to carry on normal activity; minor signs or symptoms of disease | 40 % Disabled; requires special care and assistance |
| 80 % Normal activity with effort, some signs or symptoms of disease | 30 % Severely disabled; hospitalization is indicated, although death not imminent |
| 70 % Cares for self; unable to carry on normal activity or do active work | 20 % Very sick; hospitalization is necessary; active supportive treatment is required |
| 60 % Requires occasional assistance, but is able to care for most personal needs | |

7. BLOOD TESTS

Date _____

Blood counts	Hb _____	RBC _____	WBC _____	PLT _____
		TSH _____	fT3 _____	fT4 _____
Renal parameters		Creatinine _____	GFR _____	
Liver enzymes		ALT (GOT) _____	AST (GPT) _____	GGT _____
Liver function test		Albumin _____ (g/l)	INR/PT _____	Bilirubin _____

8. TUMOR MARKERS

CgA _____ µg/l (normal _____) date _____
 Serotonin _____ µg/l (NB _____) date _____