St. Mary's General Hospital
Radiation Therapy Device Worksheet

Radiation Treatment Details (to be completed by Medical Physicist/Radiation Therapy Staff)	**Radiation Risk**
Diagnosis: _____ Start Date:_____ Radiation Site: _____ Frequency of Treatment: _____ # of Fractions: _____ Radiation Oncologist: _____ Contact Information: _____ Radiation energy: • Photons: ☐6MV ☐10MV ☐Other: _____ • Electrons: ☐20MeV ☐Other: _____ • Other: _____ ***Cumulative dose estimate: _____ Gy*** Manufacturer dose limit: _____ Gy (*where available)	Low Risk ***High Risk*** >10 MV photons for PPM >6 MV photons for ICD >20 MeV electrons Any proton therapy >5 Gy cumulative dosing Comments: _____ _____ _____

* Departmental dose limit: 2 Gy (pacemaker and defibrillators) - to be used where manufacturer limits unavailable
In general, dose to the device <2 Gy if the radiation field is ≥5 cm away from the device

Device Clinic Assessment (to be completed by CVT tech)	**Clinical Risk**
Type of Device: ☐Pacemaker ☐Defibrillator ☐CRT Manufacturer: _____ Model: _____ Indication(s) for implantation: _____ Date of last device interrogation: _____ Device location: ☐L. chest ☐R. chest ☐Other: _____ Dependency ☐Yes ☐No Underlying rhythm:_____ Magnet rate _____ Magnet response: ☐asynchronous pacing ☐disable tachy therapies	Low Risk ***High Risk*** Comments: _____ _____ _____

Device Recommendations During and After Radiation Therapy

☐Vital sign monitoring during each individual radiation treatment (pulse oximeter applied by RT staff)
☐Magnet application during each individual radiation treatment

☐Device check at start** of radiation + at end of treatment (*LOW radiation AND clinical risk*)
☐Device check at start** of radiation + weekly throughout treatments (*HIGH risk in either category*)
****** ideally before start date, otherwise first available

Additional Information or Recommendations:
_____
_____

Cardiologist Name & Signature: _____
Telephone/Pager #: Phone: (519) 749-6567, Fax: (519) 749-6874

Date: _____ **Time:** _____

Fax this form and any associated documentation to the following number NO LATER THAN 1 WEEK PRIOR TO TREATMENT *(Fax: (519) 749-6874)*