Patient name:

Please provide the radiation therapy treatment start date (MM/DD/CCYY): _______ / _______ / _______

1. Is the treatment being directed to the primary site (breast)?
   If no, please submit a request for the metastatic site being treated.
   □ Yes  □ No

2. Does the patient have distant metastatic disease (M1 stage)?
   □ Yes  □ No

3. Please check the box indicating the intent of the treatment (select one only).
   □ Adjuvant/prevention of locoregional recurrence
   □ Treatment of clinically apparent tumor that is asymptomatic
   □ Palliation of clinically apparent tumor at chest wall/breast

   If palliative go directly to question #7

4. Please check box to indicate the T-stage (pathologic T-stage if patient has had surgery).
   □ T1  □ Ductal carcinoma in situ (DCIS)
   □ T2
   □ T3
   □ T4  □ Recurrent

5. a. Are you treating the internal mammary lymph nodes?
   b. Is the mid-tangential treatment separation greater than 25.5 cm?
   c. Is the bra cup size D or greater?

6. Please select the treatment plan to be executed for the initial phase (select one only).
   □ Whole breast
   □ Chest wall radiotherapy
   □ Partial breast radiotherapy

7. Is this a request for inverse planned IMRT?
   □ Yes  □ No

8. Have you considered a forward planned IMRT treatment plan for this patient?
   □ Yes  □ No

9. Note any additional information in the space below.

Completed by: ________________________________________                          Date: ______________________________________