

REGISTRATION FOR PSMA RADIO-LIGAND THERAPY (PRLT)

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

Prostate Cancer Oncologist

Name _____

Address _____

Mail _____

Oncologist nearby

Name _____

Address _____

Mail _____

Primary Care physician

Name _____

Address _____

Mail _____

PSMA-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

Prostate adenocarcinoma	<input type="text"/>	Gleason Score	<input type="text"/>
First Diagnosis established in (M Y)	<input type="text"/>	Initial PSA level	<input type="text"/>
TNM stage	<input type="text"/>		

History of present illness / Summary of previous treatments

Please complete in chronological order (from / to)

Primary tumor resection

No

Yes

Date

External beam radiation therapy (EBRT)

No

Yes

Specify (date / type)

Chemotherapy

No

Yes

Specify (date / type)

Immunotherapy

No

Yes

Specify (date / type)



Previous androgen deprivation therapy (ADT) / hormonal treatment

Bicalutamide	No	Yes
LHRH agonists / antagonists (e.g. Lupron)	No	Yes
Please mention the generic / drug name _____		

If ongoing, dosing interval	every 3 months	every month	other
Last injection (M Y) _____			

Zytiga (Abiraterone)	No	Yes	Dose mg/day
Xtandi (Enzalutamide)	No	Yes	Dose mg/day

Osteoprotective therapy

Bisphosphonate therapy	No	Yes	Dose mg/day
Denosumab (XGEVA)	No	Yes	Dose mg/day

3. CURRENT MEDICATION

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

4. ACCOMPANYING DISEASES

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

Surgery for benign diseases:

5. CLINICAL SYMPTOMS

Height _____ cm

Weight _____ kg

weight loss
 weight gain
 constant

kg in _____ months
 kg in _____ months

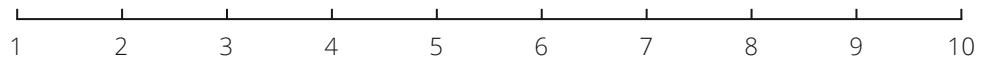
Dyspnea No Yes
 Dyspnea upon exertion No Yes

Pain No Yes

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	Hemoglobin _____	RBC _____	WBC _____	PLT _____
Renal parameters	Creatinine _____	GFR _____		
ALKALINE Phosphatase	(ALP) _____			
Lactate dehydrogenase	(LDH) _____			
Liver function test	Albumin _____ (g/l)	INR / PT _____		

8. TUMOR MARKERS

The last 3 results

PSA _____ ng/l	(normal _____)	date _____
PSA _____ ng/l	(normal _____)	date _____
PSA _____ ng/l	(normal _____)	date _____

Testosterone level _____
normal range _____