Patient ID #:_________________________________________ Date: __/__/____

Type of Radiation Received:
☐ Whole Breast Irradiation Only
☐ Whole Breast Irradiation and Regional Nodal Irradiation
☐ Partial Breast Irradiation
☐ Post Mastectomy Irradiation – Chest Wall Only
☐ Post Mastectomy Irradiation – Chest Wall and Regional Nodes
☐ No Radiation Received

RT Begin Date ☐☐☐☐ MM DD Year
RT End Date ☐☐☐☐ MM DD Year

I. Radiation Dose to Whole Breast or Chest Wall

1. Total dose prior to boost ______.____ Gy
2. Total # of fractions __________

Boost to Lumpectomy Cavity or Chest Wall Scar
1. Was a boost given? ☐ Yes ☐ No
2. Boost site ☐ Chest Wall ☐ Lumpectomy bed
3. RT Total dose to boost field ______.____ Gy
4. Total # of fractions to boost field __________
5. Time Point: ☐ Intra-Op ☐ or ☐ Post-Op

II. Radiation Dose to Targeted Regional Nodes (if applicable)

A) Nodal Regions Targeted (Check all that apply)
   Axillary ☐
   Supraclavicular / Axillary Level 3 ☐
   Internal Mammary Nodes ☐

B) Total Dose to nodal regions ______.____ Gy
C) Total # of Fractions __________
III. Partial Breast Irradiation

A) Total dose delivered: _____ ______. ___Gy
B) Total Number Fractions: __________
C) # of Fractions delivered daily: __________
D) Partial Breast Irradiation Method
   1. Interstitial Brachytherapy □
   2. Intra-cavitary Brachytherapy Device (MammoSite, Contour, ClearPath, etc.) □
   3. Intra-Op □
   4. 3-D CRT □
   5. IMRT □
   6. Protons □
   7. Other □_______________