

Patient Identification -- ← **Primary**
Boost

Site Sequential ID #

REV G - JULY 2004

1. Date of visit / /
M M D D Y Y Y Y

2. Adverse Events Were there any adverse events? Yes No

If yes, specify event by type in the provided space and complete all information. See Page 2 for definitions for "Grade" and "Type" for each type of Adverse Event and for specific codes for relationship of the event to device.

Event <i>Radiation Dermatitis</i>	Ongoing from last visit?	CTC Grade	Device Related? (1-5)	Start Date mm/dd/yy	Stop Date mm/dd/yy	Event under OBS?	SAE (✓)	Grade I	Grade II	Grade III	Grade IV		
1	Y N			___/___/___	___/___/___	Y N		<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> A <input type="checkbox"/> B		
2	Y N			___/___/___	___/___/___	Y N		<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/> A <input type="checkbox"/> B		
Event <i>Seroma Cavity</i>								Seroma Type (1-3) (Select only one)		Seroma Treatment (1-3) (Select only one)			
1	Y N			___/___/___	___/___/___	Y N		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 _____				
2	Y N			___/___/___	___/___/___	Y N		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 _____				
Event <i>Subcutaneous Tissue Change</i>								Grade I	Grade II	Grade III	Grade IV		
1	Y N			___/___/___	___/___/___	Y N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2	Y N			___/___/___	___/___/___	Y N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Event <i>Abscess/Infection</i>								Infection Location (1-3)	Infection Treatment (1-7)	Treatment Surgery Start Date	Treatment Surgery Stop Date	Treatment Surgery Start Date	Treatment Surgery Stop Date
1	Y N			___/___/___	___/___/___	Y N							
2	Y N			___/___/___	___/___/___	Y N							
Event <i>Skin - Late RT Changes</i>								Grade I	Grade II	Grade III	Grade IV		
1	Y N			___/___/___	___/___/___	Y N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2	Y N			___/___/___	___/___/___	Y N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Event <i>Other Adverse Events</i>								Interventional Comments					
1	Y N			___/___/___	___/___/___	Y N							
2	Y N			___/___/___	___/___/___	Y N							
3	Y N			___/___/___	___/___/___	Y N							
4	Y N			___/___/___	___/___/___	Y N							