XOFIGO® (RADIUM 223 DICHLORIDE) THERAPY REFERRAL DATA SHEET
Biomedical Research Foundation of Northwest Louisiana
Positron Emission Tomography (P.E.T.) Imaging Center
Scheduling Phone: 318-675-4042 Fax: 318-675-4020
Toll Free: 1-888-685-1152

PATIENT NAME: _____
print

PHYSICIAN: _____ _____
print signature of referring physician

NOTE: THIS REFERRAL COVERS THERAPY CONSISTING OF SIX (6) XOFIGO® TREATMENTS AT APPROXIMATELY ONE MONTH INTERVALS

Oncologist please complete the following:
Indication for Xofigo® treatment: _____

If Prostate Cancer:
Does the patient have a confirmed diagnosis of prostate cancer: YES / NO
Is the disease Castration Resistant (CRPC) or Hormone Refractory (HRPC): YES / NO
Is the disease bone predominant with no lung, liver and/or brain metastasis: YES/NO

Does the patient have at least 2 bone metastases on a bone scan: YES/NO
If Yes, Date of bone scan: _____

Does the patient have symptomatic disease (regular use of analgesics for bone pain or EBRT for bone pain within the last 12 weeks): YES / NO

Does the patient have a life expectancy of > 6 months: YES / NO

Does the patient have an Eastern Cooperative Oncology Group (ECOG) Performance Status (PS) of 0-2: YES / NO

Has the patient had cytotoxic chemotherapy within the last 4 weeks; YES / NO

Is there any intention to use cytotoxic chemotherapy in the next 6 months: YES / NO

Has the patient received radiation therapy to > 25% of bone marrow: YES / NO

Has the patient received previous radionuclide therapy for bone metastases: YES / NO

Baseline & Hematological Status:

- Age of Patient: _____
- Absolute Neutrophil Count (ANC): _____ on _____
- Is ANC < 1.5 x 10^9/L: _____
- Platelet Count: _____ on _____
- Is Platelet Count < 100 x 10^9/L: _____
- Hemoglobin (Hb): _____ on _____
- Is Hb < 10.0g/dL: _____
- PSA Level: _____ ng/mL on _____

Please also submit your patient's bone scan results, lab results, and clinical notes with this referral form. ***Patients cannot be scheduled without the information on this form being complete and signed by the referring physician (required by CMS (Medicare) and private insurance carriers).***

Person faxing information: _____ **Phone #** _____