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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 口腔管理診療実績表   |  |  | | --- | --- | | 記入年月日 | 年　　　月　　　日 |  |  |  | | --- | --- | | 申請者氏名 |  | | 施設・診療科名 |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | １．症例一覧表　期間　　　　年　　月　～　　　年　　月 | | | | | | No | ID番号 | 部位/総線量 | 主たる管理内容  （口腔乾燥症管理/  顎骨壊死管理等） | 放射線治療の種類  （外照射，小線源治療 **※1**） | | | 1 |  |  |  |  | | 2 |  |  |  |  | | 3 |  |  |  |  | | 4 |  |  |  |  | | 5 |  |  |  |  | | 6 |  |  |  |  | | 7 |  |  |  |  | | 8 |  |  |  |  | | 9 |  |  |  |  | | 10 |  |  |  |  | | 11 |  |  |  |  | | 12 |  |  |  |  | | 13 |  |  |  |  | | 14 |  |  |  |  | | 15 |  |  |  |  |   申請者が実施したことを証明する。　　　歯科放射線指導医　署名 |

※1 外照射であれば3D-CRT, IMRT, SBRT, PT, CIRT, BNCT、小線源治療であればLDR, HDRの別を記載

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **続き**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | １．症例一覧表　期間　　　　年　　月　～　　　年　　月 | | | | | | No | ID番号 | 部位/総線量 | 主たる管理内容  （口腔乾燥症管理/  顎骨壊死管理等） | 放射線治療の種類  （外照射，小線源治療 **※1**） | | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |   申請者が実施したことを証明する。　　　歯科放射線指導医　署名 |

※1 外照射であれば3D-CRT, IMRT, SBRT, PT, CIRT, BNCT、小線源治療であればLDR, HDRの別を記載