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| 口腔管理診療実績表

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| 記入年月日 | 　　　年　　　月　　　日  |

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| 申請者氏名 |  |
| 施設・診療科名 |  |

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| 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**） |
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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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 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**） |
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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