RADIATION

Radiation oncologist's name: _____ Phone number: _____

Facility name: _____ Phone number: _____

Address: _____

Date of Radiation	Type of Technology*	Area Treated Include shielded areas	Amount per Session	Total Dose

Any major complications from therapy: _____

_____

Side effects: _____

_____

*linear accelerator, radioactive seeds, radiation ablation, etc