

Name – patient ID  <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">-</span> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">-</span> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-between; font-size: 8px; margin-top: 2px;"> <span>Day</span> <span>Month</span> <span>year</span> <span>No.</span> </div>	Hospital, department
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**Instructions:** This form should be completed before inclusion in the protocol. Only if all the boxes of the selected column is ticked, the patient is suitable for treatment according to the protocol. The form is available on DBCG’s website ( [www.dbcg.dk](http://www.dbcg.dk) ). Choose the Web entry menu, enter Username and Password, follow the instructions as described.

<b>Inclusion criteria:</b>	
Histologically proven invasive breast carcinoma pTx-T4, pN0-N3, M0 or operated after primary systemic therapy for inv. breast carcinoma ypT0-3, ypN0-3, M0 or operated for ductal carcinoma <i>in situ</i> with indication for RT	<input type="checkbox"/> yes <input type="checkbox"/> no
Woman aged ≥ 18 years	<input type="checkbox"/> yes <input type="checkbox"/> no
WHO performance 0-2	<input type="checkbox"/> yes <input type="checkbox"/> no
Randomisation within 42 days after last surgery or within 4 weeks after last chemotherapy	<input type="checkbox"/> yes <input type="checkbox"/> no
Capable of completing therapy, planned follow up visits and investigations	<input type="checkbox"/> yes <input type="checkbox"/> no
Fertile women: uses contraception if relevant	<input type="checkbox"/> yes <input type="checkbox"/> no
Charlsons morbidity form and pathology form are available	<input type="checkbox"/> yes <input type="checkbox"/> no
Informed approval to trial (signed patient folder): <div style="display: flex; justify-content: center; align-items: center; margin-top: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: center; font-size: 8px; margin-top: 2px;"> <span style="margin: 0 10px;">dd</span> <span style="margin: 0 10px;">mm</span> <span>yy</span> </div>	<input type="checkbox"/> yes <input type="checkbox"/> no

<b>Exclusion criteria:</b>	
Previous breast cancer or DCIS	<input type="checkbox"/> no <input type="checkbox"/> yes
Previous RT to breast / thorax	<input type="checkbox"/> no <input type="checkbox"/> yes
Concurrent / previous malignancy which may influence therapy or follow up	<input type="checkbox"/> no <input type="checkbox"/> yes
Pregnant or lactating	<input type="checkbox"/> no <input type="checkbox"/> yes

Selected for this trial based on (at least 1 box needs a tick off)	<input type="checkbox"/> High dose to heart <input type="checkbox"/> High dose to lung
Systemic therapy	<input type="checkbox"/> Endocrine or no systemic therapy <input type="checkbox"/> Chemotherapy (incl. endocrine / trastuzumab)
Type of RT	<input type="checkbox"/> breast only <input type="checkbox"/> loco-regional
Connective tissue disease If yes; diagnosis _____	<input type="checkbox"/> no <input type="checkbox"/> yes

<b>Filled by DBCG</b> Randomization no. <div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div> Result of randomization : <input type="checkbox"/> PROTONS <input type="checkbox"/> PHOTONS Date <div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div> ddmmyy	<b>Form filled in by:</b> Name: _____ <div style="text-align: center; font-size: 8px;">(CAPITAL LETTERS)</div> Sign.: _____ Date <div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div> ddmmyy
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