FORM TITLE: **Radiation and ADT Summary**

Relevant SOP: Treatment Assessment and Data Monitoring (SOP TA)

Instructions: *Complete this form after radiation and ADT completed and attach copies of relevant documentation. Submit completed form and attachments to Sponsor. If adverse events occurred during radiation & not previously reported, record on a CRF TA and submit.*

Protocol Case #:_____ **Clinical Site:** _____

Patient Name:_____ **or Initials and DOB:** _____, _____MM/_____DD/_____YY

A. Radiation Therapy Summary

Radiation Start Date: ____/____/____End Date: ____/____/____ ☐ Radiation summary attached

Total Radiation Dose to the PTV: _____ Gy (*To conform to protocol the required prescription dose to PTV should not exceed the prescription dose regimen listed below by more than 7%. At least 95% of the PTV should receive the prescribed dose)* IGRT is required for moderate hypofractionated regimens.*

Radiation Regimen:
☐ Standard fractionated radiation (78Gy in 2Gy dose fractions, or similar local standard e.g. 79.2Gy in 1.8Gy dose fractions, 81Gy in 1.8Gy fractions; all fields treated once daily, 5 fractions per week).

☐ Moderate hypofractionated radiation (60Gy in 3Gy dose fractions or 70Gy in 2.5Gy fractions; all fields treated once daily, 5 fractions per week). *IGRT is required for moderately hypofractionated regimens.

Please specify below if there were any interruptions, delays* or other deviations from the protocol:

If prescribed dose, as stated above, is not received or there was a delay in start of radiation please complete a variance (VR) form.

B. Was Androgen Deprivation Therapy Used? ☐ No ☐ Yes*

**If YES, record details below or attach institutional document that provides this information. ☐ Check if attached.*

LHRH (GnRH) Agonist	Dose, Route and Schedule	Dates Received
☐ Leuprolide (e.g. Lupron, Eligard) ☐ Goserelin (Zoladex) ☐ Other, specify :		
Anti-Androgen	**Dose, Route and Schedule**	**Dates Received**
☐ Bicalutamide (e.g Casodex) ☐ Flutamide ☐ Other, specify :		
Any Interruptions in ADT Treatment? ☐ Yes ☐ No If yes, please specify:		

_____ _____MM/_____DD/_____YY

Name and Signature of Investigator who reviewed this form **Date**

Fax (617-916-5444) or email (crf@candeltx.com) to Candel Therapeutics**.**