

*Protocol #: _____ *Registration #: _____
 *Radiotherapy Dept: _____
 Physicist/ Dosimetrist: _____
 Radiation Oncologist Name: _____ Radiation Oncologist Email: _____

CLINICAL DATA

Primary Site: _____ Clinical Stage: _____ TNM Stage: T _____ N _____ M _____
 Histology: _____ Has patient had a biopsy? (Y/N) _____ Date: _____
 Has patient had a surgical excision? (Y/N) _____ Date: _____
 _____ Complete Resection _____ Incomplete Resection _____ Microscopic Residual _____ Gross Residual _____ Inoperable
 Describe the original tumor location and size _____

DATE OF FIRST TREATMENT _____

Treatment Technique

Check off all that apply: _____ 3D Conformal _____ TomoTherapy _____ IMRT (SMLC or DMLC)
 _____ Rotational IMRT _____ Motion Management _____ IGRT _____ SBRT
 _____ Other _____

Heterogeneity Calculations: _____ Yes _____ No Bolus Thickness if used: _____ cm
 Treatment Planning System _____ Patient Position _____

➤ Must Include Treatment Planning System Summary Reports (which includes monitor unit calculations, beam parameters, calculation algorithm and volume of interest dose statistics pages) with data submission.

Protocol Treatment Site	Target Volume Name	Daily Dose (cGy)	Total Number of Fractions	Total Dose (cGy)	Prescription Isodose Surface (e.g. 95%)	Number of Beams	Beam energy (e.g. 6X, 6e)
Phase #1							
Phase #2							
Phase #3							
Intended Total							

This form was completed by:

*Print Name: _____
 *Date: _____
 *Email: _____
 *Phone: _____

Please save and submit along with the digital RT plan to QARC via sFTP

Or

Attach form and email to: DataSubmission@qarc.org

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