

**Quality Assurance Review Center
 RT-2 Radiotherapy Total Dose Record**

At completion of radiotherapy submit this form with all radiotherapy data required.

*Protocol #: _____ *Registration #: _____			
*Radiotherapy Dept: _____			
Physicist/Dosimetrist: _____			
Radiation Oncologist Name: _____		Radiation Oncologist Email: _____	
List Names Of Target Volumes Corresponding To Those On RT-1 Forms, Record Boost Volumes Separately			
Name of Target Volume (i.e. PTV1, Chest)			
Date of First Treatment to the Target Volume			
Number of Treatments			
Date of Last Treatment			
Total Dose To Treatment Point (Central Axis)			
Interruptions			
From:	To:	Reason:	
From:	To:	Reason:	
From:	To:	Reason:	
From:	To:	Reason:	
Off Protocol Therapy			
Date:	Reason:		
Discontinued Radiotherapy			
Date:	Reason:		

This form was completed by:

*Print Name: _____

*Date: _____

*Email: _____

*Phone: _____

Please save and submit to QARC via sFTP

Or

Attach form to Email: DataSubmission@qarc.org

Please do not **submit** duplicate copies