QARC
QUALITY ASSURANCE REVIEW CENTER

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Quality Assurance Review Center
RT-1 Dosimetry Summary Form

*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 to Email to abbviem14360@qarc.org

Please do not **submit** duplicate copies

Copy this page for additional treatment phases as needed

*Required