QARC
QUALITY ASSURANCE REVIEW CENTER

QARC
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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 to Email to abbviem14360@qarc.org

Please do not **submit** duplicate copies

27 October 2016

***Required**