

**IROC Rhode Island QA Center (QARC)
RT-1 Dosimetry Summary Form**

PT initials: _____ *Protocol #: _____ *Registration #: _____
 Date of Birth: _____ Sex: M ___ F ___ *Radiotherapy Dept: _____
 Physicist/ Dosimetrist: _____ RTF#: _____
 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 _____

➤ **Note: If Protons are used for treatment, please use the Proton Reporting form instead.**

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 IROC QA Center via sFTP

Or

Attach to Email to Datasubmission@qarc.org

Please do not **submit** duplicate copies