IROC Rhode Island QA Center (QARC)
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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

____ 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

Copy this page for additional treatment phases as needed *Required 30 June 2016