

Motion Management Reporting Form

PT initials: _____ *Protocol #: _____ *Registration #: _____
 Date of birth: _____ Sex M ___ F ___ *Radiotherapy Dept: _____
 Physicist/ Dosimetrist: _____ RTF#: _____
 Radiation Oncologist Name: _____ Radiation Oncologist Email: _____

I. Assessment of Lesion Motion due to Respiration

- A. How did you assess motion of the lesion with respiration for this patient?
 _____ fluoroscopy _____ 4D CT _____ inspiration/expiration fast-CT scan
 _____ other: Please describe: _____
- B. What was used to assess the motion?
 _____ lesion itself
 _____ anatomic correlates: ___ diaphragm ___ chest wall
 _____ other: Please specify: _____
 _____ implanted fiducial markers: How many? _____ What size? _____ mm
 _____ other: Please specify: _____
- C. Maximum tumor excursion in any direction prior to motion management: _____ cm

II. Method used for managing motion of the lesion with respiration?

- _____ free breathing with increased margins for PTV definition
 _____ forced shallow breathing using abdominal compression
 _____ gating of treatment with breathing cycle
 _____ active breathing control (ABC)
 _____ self-held breath-hold with respiratory monitoring (e.g., RPM)
 _____ gating during free breathing using external monitors or implanted fiducials
 _____ other: Please describe: _____
- _____ tracking motion by
 _____ moving the beam (e.g. Cyberknife)
 _____ moving the MLC's
 _____ moving the patient to follow the target
- Commercial system, if applicable _____

III. Definition of Margins

Maximum tumor excursion in any direction following motion management: _____ cm
 PTV Margins: Ant/Post _____ mm Rt/Lt _____ mm Sup/Inf _____ mm

This form was completed by:

*Print Name: _____
 *Date: _____
 *Email: _____
 *Phone: _____

Please save and submit to QARC via sFTP

Or

Attach to Email to DataSubmission@qarc.org

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