

IROC Rhode Island QA Center
TBI Summary Form for VMAT/Tomotherapy

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

Treatment Machine: Model: _____ Energy: _____

I. TBI Planning Information	
1. Average Lung Dose Rate	_____ cGy/min
2. IGRT Method	
3. IGRT Tolerances	
4. Was a virtual flash margin used for planning? If yes, how large is the margin?	_____ Yes/ _____ No _____ mm
5. Were autoplanning scripts used? (https://github.com/esimiele/VMAT-TBI)	_____ Yes/ _____ No
6. Was the junction dose verified, or will it be verified, at the VMAT/AP-PA or tomo/PA-PA match line (if applicable)? If so, how? (Example: In-vivo dose measurement or dose summation based on image registration)?	_____ Yes/ _____ No

7. Dose per Fraction to Prescription Point (cGy)	
8. Number of Fractions per Day	
9. Total Dose to Prescription Point (cGy)	
10. Dose Rate at Prescription Point (cGy/min)	
11. Treatment Position	

II. FRACTIONATION SCHEDULE

FRACTION	DATE	TIME OF TREATMENT
#1		
#2		
#3		
#4		
#5		
#6		
#7		
#8		

This form was completed by:

*Print Name: _____

*Date: _____

*Email: _____

**Please save and submit along with the RT data to
IROC QA Center via sFTP.**

Please do not **submit** duplicate copies.