IROC
IMAGING AND RADIATION ONCOLOGY CORE
*Global Leaders in Clinical Trial Quality Assurance*

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# IROC Rhode Island QA Center
# RT-1 Dosimetry Summary Form

**Note: Please use Proton Reporting form for proton treatments.**

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 _____
____ Yes ____ No *Vertebral Body Sparing Technique

*Please answer for studies utilizing vertebral body sparing techniques.

Heterogeneity Calculations: ____ Yes ____ No Bolus Thickness if used: _____cm

Treatment Planning System _____ Patient Position _____

| 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: _____

**Please review the protocol for submission requirements.**

Copy this page for additional treatment phases as needed *Required 01FEB2024