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

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IROC Rhode Island QA Center
TBI Summary Form for Conventional

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. PRESCRIPTION POINT DATA	Field I	Field II	Field III	Field IV
1. Field Name (R. Lat., L. Lat., etc.)				
2. Depth of Prescription Point (cm) (1/2 thickness at the Umbilicus)				
3. Distance from source to prescription point (cm) (distance = SSD + depth)				
4. Collimator Setting in cm				
5. Transmission Factor (s) a) Tray				
b) Other (describe) ________________________ ____				
6. Monitor Units (minutes if Co- 60)				

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	

REFERENCE POINT DATA – Record the total dose for the following points as required in the protocol and defined in the protocol guidelines. (This list may include more points than required or may not include all of the required points for this specific protocol.)

A. Head ___________________ cGy

B. Neck ___________________ cGy

C. Mid-Mediastinum ______________ cGy

D. Lung (mid R) _________________cGy

*Required

E. Umbilicus _______________ cGy (prescription point)

F. Hip (Pelvis) _____________________ cGy

G. Knee ____________________ cGy

H. Ankle ___________________ cGy

CORRECTED LUNG DOSE

Dose to Lung reference point (mid right lung) at mid-mediastinum level:

Corrected for Density = ______________ cGy Not Corrected for Density = _________________ cGy

II. BEAM MODIFIERS

Attenuators over lungs: NO _______ YES _______

Material: ____________________ Thickness: ___________ cm Transmission Factor:__________

Compensator: NO _______ YES _______

Material: ____________________ Transmission Factor:_________________

Bolus: NO _______ YES _______ Material: _____________ Thickness: ___________ cm

Other: NO _______ YES _______ Describe:____

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.

*Required