

ACNS0831 DATA/FILMS CHECKLIST

QARC Contact: Dee Logan

Email: DLogan@qarc.org

Patient Identifier: _____

Registration #: _____

Radiation therapy for patients on COG protocols can only be delivered at approved COG RT facilities (see Administrative Policy 3.9, September 2007). Contact QARC for questions or further information.

This protocol requires an on-treatment review of the Initial volume and pre-treatment review of the boost volumes (see section 18.10).

RADIOTHERAPY DATA:

- _____ Required Diagnostic Imaging and Reports (see list below for required studies)
- _____ RT treatment plan submitted in digital format (refer to www.QARC.org under "Digital Data")
- _____ Prescription sheet for the entire treatment and Partial Daily RT treatment record
- _____ RT-1/ IMRT Dosimetry Summary Form or Proton Reporting Form (if applicable)
- _____ DRR's or RT simulation films for each field treated and One set of orthogonal anterior/posterior and lateral films for isocenter localization
- _____ Color isodose distributions for the composite plan in axial, sagittal, and coronal planes
- _____ Color composite DVH data for all targets and critical structures and a color composite DVH for "unspecified tissue", if IMRT is used
- _____ Treatment planning system summary report that includes the monitor unit calculations, beam parameters, calculation algorithm, and volume of interest dose statistics
- _____ Color BEV's (Beams Eye View) for all fields when IMRT is not used
- _____ Documentation of an independent check of the calculated dose if IMRT is used
- _____ For protons, a description of rationale for PTV margins
- _____ If a PTV of 3mm is used, written documentation of (IGRT) method used

FINAL RADIOTHERAPY DATA:

- _____ RT-2 Form
- _____ Copy of the daily radiotherapy record (including the prescription, monitor units and daily and cumulative doses to all required areas)
- _____ Documentation listed above showing any modifications from original submission

DIAGNOSTIC IMAGING & REPORTS:

**required for on treatment RT review*
@required for rapid central review for STR patients.
See Sec 17.1. Submit within 3 days

- _____ * @All Pre-op Cranial MRIs with and without contrast AND report
- _____ * @All Post-op Cranial MRIs with and without contrast AND report
- _____ @Pre OR Post-op Spinal MRI with contrast AND report
- _____ * @ Copies of all operative and surgical path reports
- _____ Cranial @ and Spinal MRIs with and without contrast AND reports done at the end of Induction
- _____ @Cranial MRI with and without contrast AND report done after Second Surgery
- _____ Cranial MRI with and without contrast AND report done Post radiation therapy (4 weeks post RT)
- _____ Cranial and Spinal MRIs with and without contrast AND report at the end of Maintenance Therapy
- _____ Cranial and Spinal MRIs with and without contrast AND report at Relapse (Progression)

- MAIL ALL DATA & FILMS TO: (If you need verification of receipt of this data, please write your name & e-mail address)

QARC
Suite 201
640 George Washington Highway
Lincoln, RI 02865