

AHOD03P1 DATA CHECKLIST

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Patient Initials: _____ **COG Registration #:** _____ **DATE of 1ST RT:** _____

INITIAL PRE-TREATMENT DATA (REQUIRED FOR ALL INSTITUTIONS-see section 18.8):

- _____ Prescription sheet
- _____ RT-1 Form
- _____ RT simulation/DRR films or images
- _____ Photograph(s) of patient with treatment fields marked and clearly visible
- _____ Treatment planning system summary report that includes the monitor unit calculations, beam parameters, calculation algorithm, and volume of interest dose statistics
- _____ Calculations required for reference point and critical organ doses
- _____ Color copies of isodose distributions and DVH data (if conformal planning used)
- _____ Photos of Electron fields (when applicable)
- _____ RT verification/portal films or real time portal imaging (if not for pre-RT review, then as soon as available)
- _____ All required diagnostic imaging**** (see list below)

FINAL DATA:

- _____ RT-2 Form
- _____ Daily RT Treatment Chart (including cumulative doses to all required areas, critical organs, reference points)
- _____ Additional calculations or data required to assess the RT volume(s)
- _____ RT-1 Form for subsequent field modifications
- _____ Calculations or data for subsequent field modifications
- _____ RT simulation/DRR films or images for subsequent field modifications
- _____ RT verification/portal films or real time portal imaging for subsequent field modifications

DIAGNOSTIC IMAGING (see section 17.5.3):

Date of 1st surgery: _____ **Date of 2nd surgery:** _____

The following studies and radiology reports are required at the time points identified below:

- _____ CXR (PA & Lateral)
- _____ PET Scan (FDG preferred)
- _____ CT Neck
- _____ Chest
- _____ Abdomen
- _____ Pelvis
- _____ CT (initially involved sites only, if applicable)
- _____ AHOD03P1 Staging and Response Worksheet
- _____ Operative Report(s)

Please identify the time point(s) for the study or studies included in this film submission:

- | | |
|---|--|
| _____ Baseline (Pre-Study) | _____ Post Op Following Procedure Demonstrating TR (if applicable) |
| _____ After 3 Cycles of Chemotherapy (if given) | _____ Post Op Re-evaluation (if applicable) |
| _____ Initial Pre-Biopsy (if applicable) | _____ Relapse/Progression (if applicable) |
| _____ Initial Evaluation (if applicable) | |

- MAIL ALL DATA TO:
QARC, Attn. AHOD03P1
640 George Washington Highway, Suite 201, Lincoln, RI 02865-4207

Please note if any of the items are not available.

- (If you need verification of receipt of this data, please write your name & email address):