

ARAR0331 DATA/FILMS CHECKLIST

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Patient Identifier: _____ Registration # _____

Radiation therapy for patients on COG protocols can only be delivered at approved COG RT facilities (see Administrative Policy 3.9, April 2004). Contact QARC for questions or further information.

INITIAL ON-TREATMENT DATA: Must be submitted within 3 days of start of RT

Conformal Treatment (3D or IMRT required)

- _____ Required diagnostic imaging and reports (see list below)
- _____ RT-1/ IMRT Dosimetry form
- _____ Prescription sheet for entire treatment course
- _____ DRRs/Simulation films for each field treated
- _____ RT verification (portal) films or hard copies of real time portal imaging for each volume
- _____ One set of Orthogonal A/P and Lateral films/images for isocenter localization (if portals submitted contain an orthogonal set, this is sufficient)
- _____ Treatment planning system summary report that includes the monitor unit calculations, beam parameters, calculation algorithm, and volume of interest dose statistics
- _____ Color isodose distributions for total dose plan in axial, sagittal and coronal planes (see protocol section 18.8.2.5)
- _____ Color dose volume histograms (DVHs) for the GTV, CTV, PTV normal tissues (see protocol section 18.7.3), and “unspecified tissue”
- _____ Color BEVs (Beams Eye View) for all fields and color REV (Rooms Eye View)
- _____ Photographs of patient with treatment fields marked
- _____ Independent check of the calculated dose for IMRT
- _____ Stratum B, written documentation of patient’s disease status post-Induction (CR, PR or SD)

FINAL DATA:

(If not submitted on treatment, all data/films listed in the Initial Data must be included with the Final Data)

- _____ RT-2 Form
- _____ Completed Daily Treatment Chart
- _____ Additional calculations or data required to assess the RT volume(s)
- _____ RT-1/IMRT Form for subsequent field modifications
- _____ Calculations or data for subsequent field modifications
- _____ DRRs/Simulation films and verification (portal) films/images for subsequent field modifications

DIAGNOSTIC IMAGING & REPORTS:
**required for on treatment review*

- _____ *Baseline Head/Neck MRI and report
- _____ Baseline Chest CT, Bone Scan and reports
- _____ *Treatment Planning CT scan with targets drawn
- _____ *Post Cycle 3 Head/Neck MRI and report (Stratum B)
- _____ Post Cycle 3 Chest CT, Bone Scan and reports if positive at diagnosis (Stratum B)
- _____ End of therapy Head/Neck MRI, Chest CT, Bone Scan and reports
- _____ *Copy of op report, path report and any additional surgical reports
- _____ Relapse/Progression imaging and reports

- MAIL ALL DATA & FILMS TO:
QARC
Suite 201
640 George Washington Highway
Lincoln, RI 02865-4027

If you need verification of receipt of this data, please write your name & e-mail address