

ARST0531 DATA/FILMS CHECKLIST

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Registration # _____

Initials: _____

1st RT Date: _____

INITIAL ON-TREATMENT DATA:

- _____ *Copies of all relevant Diagnostic Imaging (See list below)
- _____ Digital RT treatment plan (RTOG or DICOM format)
- _____ RT Prescription for entire treatment course
- _____ RT-1/IMRT Dosimetry Summary Form or Proton Reporting Form
- _____ Documentation of an independent check of the calculated dose (if IMRT used)
- _____ BEVs (if applicable)
- _____ DVHs
- _____ Color isodose distributions
- _____ DRRs
- _____ Portals (if applicable)
- _____ Treatment planning system summary report that includes the monitor unit calculations, beam parameters, calculation algorithm, and volume of interest dose statistics
- _____ Motion Management Form (if applicable)
- _____ A description of the rationale for the PTV margins (for protons)
- _____ If the recommended doses to the organs at risk are exceeded, an explanation should be included.
- _____ If modifications are made for patients with age < 24 months, documentation should be provided.

Please submit the following additional information for brachytherapy:

- Treatment planning CT used for post-implant dosimetry
- Computer printouts of the isodose distribution and associated CT-based calculations.
- Dose volume histograms for the GTV, CTV, and PTV.
- A completed Brachytherapy Physics Reporting Form.
- A copy of the written directive.

Please submit the following additional information for intra-operative radiation therapy:

- Daily RT treatment chart
- Physician's note describing the procedure, dose calculation and description of the applicator along with any relevant dosimetric characteristics (i.e. percent depth dose for the prescribed energy)

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
- _____ Daily RT Treatment Chart
- _____ Documentation of any modifications made since the initial submission

***DIAGNOSTIC IMAGING:**

- _____ Pre-study/pre-op MRI/CT
- _____ Response imaging (When volume reduction is done after 36 Gy)
- _____ Any other relevant diagnostic images used in treatment planning

Central Review of Imaging:

These are Optional. Please check here if not done: _____

_____ PreStudy PET scan _____ Week 4 PET scan _____ Week 15 PET scan

MAIL ALL DATA & FILMS TO: QARC, Attn. ARST0531
Suite 201, 640 George Washington Highway
Lincoln, RI 02865-4207

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