

**Quality Assurance Review Center
RT-2 Radiotherapy Total Dose Record**

Quality Assurance Review Center
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At completion of radiotherapy submit this form with all radiotherapy data required.

Coop Group _____	*Protocol # _____	*Registration # _____
PT initials _____	Date of birth _____	Sex M ___ F ___
Physicist/ Dosimetrist _____	Radiation Oncologist _____	
Radiotherapy Dept. _____		

List Names Of Target Volumes Corresponding To Those On RT-1 Forms, Record Boost Volumes Separately			
Name of Target Volume (i.e. PTV1, Chest)			
Date of First Treatment to the Target Volume			
Number of Treatments			
Date of Last Treatment			
Total Dose To Treatment Point (Central Axis)			
Critical Structure	Max Dose	Critical Structure	Max Dose
A.		D.	
B.		E.	
C.		F.	
Interruptions			
From:	To:	Reason:	
From:	To:	Reason:	
From:	To:	Reason:	
From:	To:	Reason:	
Off Protocol Therapy			
Date:	Reason:		
Discontinued Radiotherapy			
Date:	Reason:		

This form was completed by:

Print Name: _____

Date: _____

Email: _____

Phone: _____

Please save and submit to QARC via sFTP

Or

Please do not resubmit this form by fax or mail.

***Required**