

**Quality Assurance Review Center  
Brachytherapy Physics Reporting Form**

*This form is to be completed by Physicist/ Dosimetrist or Radiation Oncologist. If a Remote Afterloading Unit with a single source was used, please complete page 2.*

Coop Group _____	Protocol # _____	Registration No _____
PT initials _____	Date of birth _____	Sex M _____ F _____
Radiotherapy Dept _____	Radiation Oncologist _____	
Physicist/ Dosimetrist _____		

Please list any External Beam Dose given to the Implant Site or Critical Tissue.			
Site	Dose	Site	Dose

**IS THIS INTRA-OP?** Yes  No       **IS THIS POST-OP?** Yes  No

**Date of Surgery, if yes** \_\_\_\_\_

**SITE:** \_\_\_\_\_

**PROCEDURE:**     intracavitary       interstitial    (  temporary,  permanent )       plaque

Radionuclide: \_\_\_\_\_ # sources \_\_\_\_\_      Total air-kerma strength \_\_\_\_\_ cGy.cm<sup>2</sup>/h or mCi \_\_\_\_\_

Type and number of applicator/source/device \_\_\_\_\_

Date, time inserted \_\_\_\_\_ removed \_\_\_\_\_ total treatment time \_\_\_\_\_ h

**TARGET VOLUME:** \_\_\_\_\_ cm<sup>3</sup>, length \_\_\_\_\_ cm, width \_\_\_\_\_ cm, thickness \_\_\_\_\_ cm

**TREATMENT PLAN:** Computer Planning System \_\_\_\_\_ Image (eg: CT) based \_\_\_\_\_ or \_\_\_\_\_ not

Dose is prescribed at \_\_\_\_\_ Prescribed dose \_\_\_\_\_ cGy, Dose rate at prescription \_\_\_\_\_ cGy/h

**SOURCE CONFIGURATION:** Sketch below: (Submit orthogonal films & isodose distributions in appropriate planes with **target volumes** and **source locations** indicated or CT-based isodose distributions & DVH's as required by protocol.)

**TREATMENT EVALUATION:** Treatment dose (TD) at prescription \_\_\_\_\_ cGy, Dose rate at prescription \_\_\_\_\_ cGy/h

Minimum target dose \_\_\_\_\_ cGy, Treatment volume (volume receiving prescribed dose) \_\_\_\_\_ cc

Treatment volume cc / Target volume cc \_\_\_\_\_

Special interest points	Dose planned, cGy	Dose delivered, cGy

**REMOTE AFTERLOADING, SINGLE SOURCE:**

**SITE:** \_\_\_\_\_

**IS THIS PROCEDURE:**      Intra-op (Yes/ No)                      Post-op (Yes/ No)

**IS THIS PROCEDURE:**       Single fraction  
 Two fractions separated by \_\_\_\_\_ hours  
 Other                      \_\_\_\_\_ (# of fractions) separated by \_\_\_\_\_ hours

**PROCEDURE:**       intracavitary               interstitial               HDR  LDR

Type of applicator/source/device \_\_\_\_\_

Radio nuclide: \_\_\_\_\_ Air-kerma strength \_\_\_\_\_ cGy, cm<sup>2</sup>/ h or mCi \_\_\_\_\_

**TARGET VOLUME:** \_\_\_\_\_ cm<sup>3</sup>, length \_\_\_\_\_ cm, width \_\_\_\_\_ cm, thickness \_\_\_\_\_ cm

**TREATMENT PLAN:** Treatment planning system \_\_\_\_\_ version, image based \_\_\_\_\_ or not \_\_\_\_\_.

Dose is prescribed at \_\_\_\_\_ Prescribed dose \_\_\_\_\_ cGy

**SOURCE CONFIGURATION:** Sketch below or submit printouts, indicating dwell-time in the various positions: (Submit isodose distributions in appropriate planes with **target volumes**.)

**TREATMENT EVALUATION:** Treatment dose (TD) at prescription \_\_\_\_\_ cGy, Dose rate at prescription \_\_\_\_\_ cGy/h,

Treatment volume \_\_\_\_\_ cm<sup>3</sup>, Minimum target dose \_\_\_\_\_ cGy, Treatment volume cc/ Target volume cc \_\_\_\_\_

Special interest points	Dose planned, cGy	Dose delivered, cGy

This form was completed by:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**SUBMIT TO:**      Quality Assurance Review Center  
 Suite 201  
 640 George Washington Highway  
 Lincoln, RI 02865-4207  
 Email: [Physics@QARC.org](mailto:Physics@QARC.org)

This reporting form is based upon Recommendations of the American Endocurietherapy Society, published in Endocurie. Hypertherm. Oncol. Vol. 7, 1991, 1-12, where the concepts and the quantities are defined and discussed