



Quality Assurance Review Center IORT Physics Reporting Form

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

Primary Site _____ **Stage** _____

- Treatment machine: _____
Electron energy (MeV): _____
Photon energy (MV): _____
Orthovoltage (kV): _____
- Treatment Field Size (cm x cm): _____
- Treatment Distance (cm): _____
- Dose Prescribed at _____ depth
This is _____ D_{max}, _____ 90%, _____ 80% or _____ other (please specify)
- Bolus thickness (cm) _____
No bolus

This form was completed by _____
Phone: _____ Fax: _____
Email: _____

For intra-operative brachytherapy, please complete the Brachytherapy Physics Reporting form.

If treating with IORT, please return this completed form and supporting documents to:

Submit to: Quality Assurance Review Center
Suite 201
640 George Washington Highway
Lincoln, RI 02865-4207
Phone: (401) 753- 7600
FAX: (401) 753- 7601
Email: Physics@QARC.org