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IROC Rhode Island QA Center (QARC)
RT-1 Dosimetry Summary Form

Note: Please use Proton Reporting form for proton treatments.

PT initials: _____ *Protocol #: _____ *Registration #: _____

Date of Birth: _____ Sex: M ____ F ____ *Radiotherapy Dept: _____

Physicist/ Dosimetrist: _____ RTF#: _____

Radiation Oncologist Name: _____ Radiation Oncologist Email: _____

CLINICAL DATA

Primary Site: _____ Clinical Stage: _____ TNM Stage: T _____ N _____ M _____

Histology: _____ Has patient had a biopsy? (Y/N) ____ Date: _____

Has patient had a surgical excision? (Y/N) ____ Date: _____

____ Complete Resection ____ Incomplete Resection ____ Microscopic Residual ____ Gross Residual ____ Inoperable

Describe the original tumor location and size:

DATE OF FIRST TREATMENT _____

Treatment Technique

Check off all that apply: ____ 3D Conformal ____ TomoTherapy ____ IMRT (SMLC or DMLC)

____ Rotational IMRT ____ Motion Management ____ IGRT ____ SBRT

____ Other _____

____ Yes ____ No *Vertebral Body Sparing Technique

*Please answer for studies utilizing vertebral body sparing techniques.

Heterogeneity Calculations: ____ Yes ____ No Bolus Thickness if used: _____cm

Treatment Planning System _____ Patient Position _____

Protocol Treatment Site	Target Volume Name	Daily Dose (cGy)	Total Number of Fractions	Total Dose (cGy)	Prescription Isodose Surface (e.g. 95%)	Number of Beams	Beam energy (e.g.6X, 6e)
Phase #1							
Phase #2							
Phase #3							
Intended Total							

This form was completed by:

*Print Name: _____

*Date: _____

*Email: _____

Please review the protocol for submission requirements.

Copy this page for additional treatment phases as needed *Required 09 March 2023