IROC Rhode Island QA Center (QARC)
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IROC Rhode Island QA Center (QARC)
RT-2 Radiotherapy Total Dose Record

Please complete and submit this form at completion of radiotherapy with all other required data.

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

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

Physicist/ Dosimetrist _____ RTF#: _____

Radiation Oncologist Name: _____ Radiation Oncologist Email: _____

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)			

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: _____

Please review the protocol for submission requirements

*Required