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

IROC
IMAGING AND RADIATION ONCOLOGY CORE
Global Leaders in Clinical Trial Quality Assurance

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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