

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 _____

INTENDED TOTAL EFFECTIVE DOSE (for all phases): _____

DOSE PRESCRIPTION (phase 1): Target Volume Name _____ **Date of First Treatment** _____

Prescription Effective Dose per Fraction: _____	RBE used : _____
Intended Effective Dose for Phase 1: _____	Uncertainty in depth and modulation
Intended Number of Fractions: _____	Included in prescription? ___ yes / ___ no

Type: ___ Scattered ___ Uniform Scanning ___ Pencil Beam Scanning ___ IMPT
 ___ Yes ___ No *Vertebral Body Sparing Technique

*Please answer for studies utilizing vertebral body sparing techniques.

Treatment Fields (phase 1) Include Beam Data Printouts from the Planning System and Monitor Unit Calculations

Field Name (e.g. Ant, RL1A, 3A)						
Gantry Angle / Couch Angle	/	/	/	/	/	/
Prescribed depth / modulation	/	/	/	/	/	/
Custom range compensator?	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no
Monitor Units per Fraction						

This form is completed by:

*Print Name: _____
 *Date: _____
 *Email: _____

**Please review the protocol for
submission requirements.**



**IROC Rhode Island QA Center (QARC)
 Proton Dosimetry Summary Form**

(Page 2)

*Registration #: _____

*Protocol #: _____

DOSE PRESCRIPTION (phase 2): Target Volume Name _____ Date of First Treatment _____ a

Prescription Effective Dose per Fraction: _____	RBE used : _____
Intended Effective Dose for Phase 2: _____	Uncertainty in depth and modulation
Intended Number of Fractions: _____	Included in prescription? ___ yes / ___ no

Type: ___ Scattered ___ Uniform Scanning ___ Pencil Beam Scanning ___ IMPT
 ___ Yes ___ No *Vertebral Body Sparing Technique

*Please answer for studies utilizing vertebral body sparing techniques.

Treatment Fields (phase 2) Include Beam Data Printouts from the Planning System and Monitor Unit Calculations

Field Name (e.g. Ant, RL1A, 3A)						
Gantry Angle / Couch Angle	/	/	/	/	/	/
Prescribed depth / modulation	/	/	/	/	/	/
Custom range compensator?	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no
Monitor Units per Fraction						

DOSE PRESCRIPTION (phase 3): Target Volume Name _____ Date of First Treatment _____

Prescription Effective Dose per Fraction: _____	RBE used : _____
Intended Effective Dose for Phase 3: _____	Uncertainty in depth and modulation
Intended Number of Fractions: _____	Included in prescription? ___ yes / ___ no

Type: ___ Scattered ___ Uniform Scanning ___ Pencil Beam Scanning ___ IMPT
 ___ Yes ___ No *Vertebral Body Sparing Technique

*Please answer for studies utilizing vertebral body sparing techniques.

Treatment Fields (phase 3) Include Beam Data Printouts from the Planning System and Monitor Unit Calculations

Field Name (e.g. Ant, RL1A, 3A)						
Gantry Angle / Couch Angle	/	/	/	/	/	/
Prescribed depth / modulation	/	/	/	/	/	/
Custom range compensator?	yes / no	yes / no	yes / no	yes / no	yes / no	yes / no
Monitor Units per Fraction						

This form is completed by:

*Print Name: _____

*Date: _____

*Email: _____

Please review the protocol for submission requirements.