OMB#0925-0624
Expiration Date: 12/31/2013

Filling out PDF Forms

This PDF form contains "**roll-over** or **double-click "** help functionality.

This form allows you to enter data directly onto the screen. After completing the form, you are able to print the document so that you can fax/mail the document.

To fill out a form:

1. Select the hand tool.

2. Position the pointer inside a field, and click to type text.

3. After entering text or selecting a check box, do one of the following:

   - Press tab to accept the form field change and go to the next form field.

   - Press Shift+Tab to accept the form field change and go to the previous form field.

   - Press Enter (Windows) or Return (Mac OS) to accept the form field change and deselect the current form field.

4. Once completed, print the form.

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RT FACILITIES INVENTORY

NOTE: Radiation Therapy facilities participating in NCI sponsored protocols must be active in the Radiological Physics Center (RPC) Quality Assurance monitoring program. Please complete the facility personnel contact and peer review section of this form if your site participates in the RPC monitoring program and fax it to the CTSU Regulatory Office at 1-215-569-0206 or e-mail to CTSURegulatory@ctsu.coccg.org.

Sites that do not currently participate in the monitoring program must submit a complete six page form and all applicable supplemental documentation. The complete form and supplemental documentation should be faxed or emailed to the CTSU Regulatory Office.

CTSU requires a one time submission of the RT information for each facility used by your institution. Changes to contact information should be made using this form and clearly noted on the form.

Facility Information

Name _____ Also known as/Formerly known as: _____

RTF# from RPC: _____ (available at RPC site: http://rpc.mdanderson.org/rpc/)

Address (street): _____

Address (city, state, zip): _____

Phone: _____ Fax: _____

Estimated Clinical Trials Case Load per year: _____

List Institutions that this RT Facility Serves:

Name: _____ CTEP ID: _____

Name: _____ CTEP ID: _____

Name: _____ CTEP ID: _____

Name: _____ CTEP ID: _____

(Attach additional sheet if more lines are needed.)

Personnel

Radiation Oncologist Senior Investigator

Name _____

Address _____

RT FACILITIES INVENTORY

Phone/Fax/E-mail _____

CRA(s):

Name _____

Address _____

_____

Phone/Fax/E-mail _____

Radiation Oncologists

Name _____

Address _____

_____

Phone/Fax/E-mail _____

Physicist(s)

Name _____

Address _____

_____

Phone/Fax/E-mail _____

Dosimetrist(s)

Name _____

Address _____

_____

Phone/Fax/E-mail _____

Radiation Oncologist Therapists

Name _____

Address _____

Phone/Fax/E-mail _____

Peer review

Do you actively participate in RPC TLD monitoring program? No ☐ Yes ☐

If Yes, Most Recent RPC Report Date_____

♣♣♣ (Stop – Do not complete the remainder of this form if your facility is RPC monitored] ♣♣♣

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RT FACILITIES INVENTORY

Equipment

Megavoltage Machine(s)

Model	Manufacturer	Serial #	Date Installed	X-Ray Energy	Electron Energies

Simulation Equipment:

Does your Radiation Oncology Department have a dedicated CT unit? No ☐ Yes ☐

If yes, Model/Manufacturer: _____

If no, list other simulation equipment/system manufacturer/model: _____

_____

Ancillary Equipment

Is your institution equipped to perform stereotactic radiosurgery? No ☐ Yes ☐

Is your institution equipped to perform HDR brachytherapy? No ☐ Yes ☐

Is your institution equipped to perform MammoSite® treatments? No ☐ Yes ☐

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Is your institution equipped to perform LDR interstitial brachytherapy? No ☐ Yes ☐

If yes, what isotopes: _____

Does your institution have a method to calibrate brachytherapy sources? No ☐ Yes ☐

Is your institution equipped to perform IMRT? No ☐ Yes ☐

If yes, what is your treatment planning system? _____

_____

If yes, what is your dose delivery technique? _____

_____

Does your institution use a record and verify system? No ☐ Yes ☐

If yes, what type: _____

Isodose Plotter/Water Phantom No ☐ Yes ☐

If Yes, Type:_____

Manufacturer:_____

Detector:_____

Film Densitometer No ☐ Yes ☐

If Yes, Manufacturer:_____

Institution's Standard Dosimeter for beam calibration Photon ☐ Electron ☐

Type	Date of last NIST traceable calibration
Ion chamber: _____	___/____/____
Electrometer: _____	___/____/____

Has your institution converted to the TG-51 calibration protocol? No ☐ Yes ☐

If yes, on what date: ____/____/20____

If no, specify the calibration protocol you currently use. _____

_____

Treatment Planning

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External beam treatment planning computer? No ☐ Yes ☐

If Yes, Make:_____

Model:_____

Version:_____

2D ☐ 3D ☐

Treatment Planning Computer for brachytherapy No ☐ Yes ☐

If Yes, Make:_____

Model:_____

CT Treatment planning system? No ☐ Yes ☐

If Yes, Manufacturer:_____

Isodose Distributions: Multiple planes? No ☐ Yes ☐

Does your facility have the capability to complete electronic data transmission to the Image-guided Therapy Center (ITC) or other organizations? No ☐ Yes ☐

Treatment Record

Typically recorded daily doses:

Gross Tumor Volume	No ☐	Yes ☐
Critical Organs	No ☐	Yes ☐
Time of Treatment	No ☐	Yes ☐

Do you have the ability to treat all fields daily for a protocol patient? No ☐ Yes ☐

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Quality Assurance

Briefly describe the QA program in existence at facility to verify equipment performance (please summarize parameters and frequency of checks).

Briefly describe the procedure utilized for assuring accuracy of each individual patient's initial dose calculations (timer/monitor units).

Who is responsible for chart checking and how often is it done?

How often are portal and/or verification films taken for each patient?

Attachments:

- Last annual full calibration report for each treatment machine that will be used in protocol studies.
- Sample of Daily Treatment Record
- Most recent TLD check if available
- Facility Quality Assurance plan &/or sample documents

Signature of Radiation Oncologist: _____

Signature of Physicist: _____

Date: ____/_____/20_____