

RADIATION THERAPY WORKSHEET

Check one or more item(s) within each category as appropriate
(Double click on box and choose "checked").

The Medical Physics Subcommittee and IROC physicists/staff will use the information for
quality assurance resource evaluation.

1.	Will RT be Administered in the Trial? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete both worksheets. If no, please complete image collection worksheet.					
2.	Treatment equipment: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; vertical-align: top;"> External Beam <input type="checkbox"/> Photon <input type="checkbox"/> Proton <input type="checkbox"/> Radiopharmaceutical </td> <td style="width: 33%; vertical-align: top;"> Brachytherapy <input type="checkbox"/> HDR <input type="checkbox"/> LDR </td> <td style="width: 34%; vertical-align: top;"> <input type="checkbox"/> Other (please specify): </td> </tr> </table>			External Beam <input type="checkbox"/> Photon <input type="checkbox"/> Proton <input type="checkbox"/> Radiopharmaceutical	Brachytherapy <input type="checkbox"/> HDR <input type="checkbox"/> LDR	<input type="checkbox"/> Other (please specify):
External Beam <input type="checkbox"/> Photon <input type="checkbox"/> Proton <input type="checkbox"/> Radiopharmaceutical	Brachytherapy <input type="checkbox"/> HDR <input type="checkbox"/> LDR	<input type="checkbox"/> Other (please specify):				
3.	Fractionation strategy: <input type="checkbox"/> Standard (1.8 to 2.5 Gy per fraction) <input type="checkbox"/> Hypo-fractionation (> 2.5 Gy per fraction) <input type="checkbox"/> Hyper-fractionation (<1.8 Gy per fraction) <input type="checkbox"/> Other (please specify):					
4.	Simulation imaging and motion management: Imaging for RT see Imaging Section (next page)					
5.	IGRT: Which forms of IGRT will you allow (check all that apply)? <input type="checkbox"/> 2D X-Ray/CBCT/CT <input type="checkbox"/> In-room MR <input type="checkbox"/> Surface Imaging <input type="checkbox"/> In-room PET <input type="checkbox"/> Other (please specify):					
6.	Do you intend to review each institution's treatment approach using any of the following techniques? Check one or more: <input type="checkbox"/> PI review of first patient's treatment plan from each institution as a Pre-Tx review (2 business days) <input type="checkbox"/> Standard Post- Hoc treatment review <input type="checkbox"/> Other (please explain):					
7.	List potential projects that justify collection of radiotherapy and imaging data, e.g., radiomics study, application of AI for decision support, etc.					

Centralized Image Collection

Provide information on all types of imaging, both treatment planning and diagnostic evaluation, that will be collected centrally for quality control and/or central evaluation for treatment or clinical endpoint determination.

Check all item(s) that apply and provide details as appropriate.

The Imaging Committee and IROC Imaging/staff will use the information for quality assurance resource evaluation/scientific collaboration resource evaluation.

Imaging Type:	Image Collection	Central Review	CT	MR	PET	SPECT	Other (specify)	Descriptions
Pretreatment Evaluation/ Staging Only (Not for treatment planning/ guidance)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anatomic <input type="checkbox"/> Yes <input type="checkbox"/> No Other (e.g., Perfusion) <input type="checkbox"/> Yes <input type="checkbox"/> No	Anatomic <input type="checkbox"/> Yes <input type="checkbox"/> No Other (e.g., DWI/DTI, fMRI) <input type="checkbox"/> Yes <input type="checkbox"/> No	FDG <input type="checkbox"/> Yes <input type="checkbox"/> No Other Tracer <input type="checkbox"/> Yes <input type="checkbox"/> No Dynamic PET <input type="checkbox"/> Yes <input type="checkbox"/> No	Tracer <input type="checkbox"/> Yes <input type="checkbox"/> No		(for example: review for tumor staging confirmation; collection for radiomics study)
Treatment (Tumor) Response Assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anatomic <input type="checkbox"/> Yes <input type="checkbox"/> No Other (e.g., Perfusion) <input type="checkbox"/> Yes <input type="checkbox"/> No	Anatomic <input type="checkbox"/> Yes <input type="checkbox"/> No Other (e.g., DWI/DTI, fMRI) <input type="checkbox"/> Yes <input type="checkbox"/> No	FDG <input type="checkbox"/> Yes <input type="checkbox"/> No Other Tracer <input type="checkbox"/> Yes <input type="checkbox"/> No Dynamic PET <input type="checkbox"/> Yes <input type="checkbox"/> No	Tracer <input type="checkbox"/> Yes <input type="checkbox"/> No		(e.g. RECIST, DSR-MRI for pseudo or true progression) Please specify timepoints:
Imaging for Radiation Treatment Planning & Guidance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anatomic <input type="checkbox"/> Yes <input type="checkbox"/> No Other (e.g., Perfusion) <input type="checkbox"/> Yes <input type="checkbox"/> No	Anatomic <input type="checkbox"/> Yes <input type="checkbox"/> No Other (e.g., DWI/DTI, fMRI) <input type="checkbox"/> Yes <input type="checkbox"/> No	FDG <input type="checkbox"/> Yes <input type="checkbox"/> No Other Tracer <input type="checkbox"/> Yes <input type="checkbox"/> No Dynamic PET <input type="checkbox"/> Yes <input type="checkbox"/> No	Tracer <input type="checkbox"/> Yes <input type="checkbox"/> No		(e.g. 4D CT)