**IGRT Questionnaire**

**Contact Information:**

Institution Name:       RTF:       CTEP Number:

Address:

Physicist name:       Physicist email:

Radiation Oncologist name:       Radiation Oncologist email:

Data manager/CRA name:       Data manager/CRA email:

Other contact name:       Other contact email:

Phone number:

**IGRT Types Used** (check all applicable)**:**

2D: [ ]  MV [ ] kV [ ]  kV fluoroscopy

CBCT: [ ] MV [ ] kV [ ] 4D

CT: [ ] MV [ ] kV

MRI: [ ]

Other:

Please list Model and Manufacturer of each system used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Registration Method**(check all applicable)**:**

[ ] Manual Registration [ ] Automated registration [ ] Automated&manual registration [ ] Other

If other, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of alignment does your site perform? [ ] Bony [ ]  Soft Tissue [ ] Fiducial [ ] tumor

Please include a detailed description of your IGRT methods including registration algorithm, patient alignment and approval procedure\_

**Motion Management (check techniques used in the clinic):**

Simulation: [ ] Free Breathing [ ]  4DCT [ ] breath hold

Treatment: [ ] Free Breathing [ ] breath hold

**Imaging QA:**

Each site is expected to follow the recommendations issued by the AAPM’s TG-179 report.

Do you perform daily tests either of isocenter coincidence or of phantom localization/repositioning?

[ ] Yes [ ] No

Do you perform monthly laser alignment QA? [ ] Yes [ ] No

Do you perform monthly couch shift QA? [ ] Yes [ ] No

Do you perform monthly Image quality QA? [ ] Yes [ ] No

Do you perform annual imaging dose QA? [ ] Yes [ ] No

If you answered no to any of the above, please explain.

**Frequency/Tolerance:**

What is your IGRT frequency (daily, weekly, etc)?       Please describe for all relevant disease sites.

What is your tolerance level for patient repositioning? Please describe for all relevant disease sites.

Do you reimage after shifting the patient? [ ] Yes [ ] No If so describe the circumstances when you do?

In what situations do you reimage the patient during the treatment?

What is your rotational tolerance       and is your treatment couch able to rotate? [ ] Yes [ ] No

Are fiducial markers used? [ ] Yes [ ] No