**IGRT Questionnaire**

*Please fill out the following information regarding your institution’s IGRT practices. All applicable questions must be filled out in order to be appropriately reviewed and processed. Should a statement or question not apply to your practice, please answer “N/A”.*

**Contact Information**

|  |  |  |
| --- | --- | --- |
| **Institution Name** | **RTF Number** | **CTEP Number** |
|       |       |       |
| **Institution Address** |
|       |
| **City** | **State** | **Zip Code** |
|       |       |       |
| **Physicist Name** | **Physicist Email** |
|       |       |
| **Radiation Oncologist Name** | **Radiation Oncologist Email** |
|       |       |
| **Data Manager/CRA Name** | **Data Manager/CRA Email** |
|       |       |
| **Other Contact Name** | **Other Contact Email** |
|       |       |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Modality** | **IGRT Type** |  | **Please list the model and manufacturer of each system used for IGRT:** |
| **2D** | [ ]  MV [ ]  kV [ ]  kV fluoroscopy |       |
| **CBCT** | [ ]  MV [ ]  kV [ ]  4D |
| **CT** | [ ]  MV [ ]  kV |
| **MRI** | [ ]  |
| **Other:** |       |

**Registration Methods** *(check all applicable)*

|  |  |
| --- | --- |
| **Registration Method** | **If Other, please specify:**       |
| [ ]  Manual Registration [ ]  Automated Registration [ ]  Automated & Manual Registration[ ]  Other  |
| **What type of alignment does your site perform?** *(check all applicable)*[ ]  Bony Anatomy [ ]  Soft Tissue [ ]  Fiducial [ ]  Tumor |
| **Please include a detailed description of your IGRT methods including registration algorithm, patient alignment and approval procedure:**      |

**Motion Management** *(check all applicable to clinical practice)*

|  |  |
| --- | --- |
| **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. Please answer the following questions regarding your imaging QA procedures.*

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** |  |
| [ ]  | [ ]  | Do you perform daily tests either of isocenter coincidence or of phantom localization/repositioning? |
| [ ]  | [ ]  | Do you perform monthly laser alignment QA? |
| [ ]  | [ ]  | Do you perform monthly couch shift QA?  |
| [ ]  | [ ]  | Do you perform monthly image quality QA?  |
| [ ]  | [ ]  | Do you perform annual imaging dose QA? |
| **If you answered NO to any of the above, please explain:**       |

**IGRT Frequency & Tolerance**

|  |
| --- |
| **What is your typical IGRT frequency (daily, weekly, etc)?**       |
| **Please describe your IGRT frequency 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 you answered YES to the previous question, describe the circumstances when you reimage.**       |
| **In what situations do you reimage the patient during the treatment?**      |
| **Is your treatment couch able to rotate?** [ ]  YES [ ]  NO |
| **If you answered YES to the previous question, what is your rotational tolerance?**       |
| **Are fiducial markers used?** [ ]  YES [ ]  NO |