**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 |