**Preliminary Self-Assessment**

*A radiation oncologist who did not provide the patient's care should complete this form. Please Check **Yes, No or NA** for categories A through L and comment as needed.*

| Category | Overall Score (Worst 1 2 3 4 5 Best; circle only one) |
|---|---|
| **A. HISTORY AND PHYSICAL / CONSULTATION** | **1 2 3 4 5** |

| Yes | No | N/A | |
|---|---|---|---|
| / | | | Dates of Treatment 1/16/2019 to 3/4/2019 |
| / | | | Disease Adenocarcinoma (prostate) Stage 3C |
| / | | | Pathology report |
| / | | | Current history of present illness/past medical history |
| / | | | Review of systems |
| / | | | Family and social history |
| | / | | Risk factors |
| / | | | Informed consent (risks, complications, benefits, alternatives, questions answered) |
| / | | | Pre-treatment numerical functional performance stated |
| / | | | Physical exam |
| | | / | Chemotherapy: Prior ❑ Post RT ❑ Concurrent ❑<br>Agents used_____ |
| If **Breast** patient, were the following items documented: | | | |
| **Yes** | **No** | **N/A** | |
| | | | Pathologic size of primary tumor |
| | | | Final margin status of resected primary tumor |
| | | | Hormone Receptor status |
| | | | Use of hormone replacement therapy |
| | | | Hormonal therapy/chemotherapy planned/given |
| **Yes** | **No** | **N/A** | |
| | | | Electron Boost |
| If **Prostate** patient, were the following items documented: | | | |
| **Yes** | **No** | **N/A** | |
| / | | | Recent pre-treatment PSA **:** 18.1 Gleason's Score: 4+5 |
| | / | | Patient's potency history prior to and after treatment documented |
| **Comments:** | | | |

## B. PRESCRIPTION/DOSE/IMMOBILIZATON

*Worst (circle only one) Best*
**1 2 3 4 5**

| Yes | No | N/A | |
|---|---|---|---|
| / | | | Signed (prior to treatment) |
| / | | | Dated (prior to treatment) |
| / | | | Site or volume in prescription |
| | | / | Treatment volume is appropriate |
| / | | | Describe treatment fields *(AP/PA, 7 field IMRT etc.)*<br>IMRT/RapidArc |
| / | | | Dose and fraction size appropriate |
| / | | | Planned total dose: 4500 cGy + 15 Gy HDR boost |
| / | | | Total number of fractions: 25 *(large field)* _____(*conedown if applicable)* |
| / | | | Dose per fraction: 180 cGy _____ cGy (*conedown if applicable)* |
| / | | | Mode and energy: Photon, per plan + HDR Brachytherapy,Ir-192 |
| / | | | Patient position Supine ☒ Prone ☐ |
| / | | | Immobilization device for reproducible set-up: Describe<br>Short Vac |

**Comments:**

## C. PATIENT EVALUATION DURING TREATMENT

*Worst (circle only one) Best*
**1 2 3 4 5**

| Yes | No | N/A | |
|---|---|---|---|
| / | | | Weekly examinations of the patient during treatment by radiation oncologist |
| | | | Progress notes include: |
| / | | | Progress/tolerance |
| / | | | Accumulated dose |
| | | / | Treatment plan change |
| | | / | Treatment break |
| / | | | Other clinical issues |

**Comments:**

*Worst* *(circle only one)* *Best*

**D. TREATMENT SUMMARY (COMPLETION)** **1 2 3 4 5**

| Yes | No | N/A | |
|---|---|---|---|
| / | | | Chart Includes Treatment Summary (if yes, answer the following) |
| | | | **Treatment summary includes:** |
| / | | | Area treated, dose (includes all treatment to volume) and energy |
| / | | | Treatment dates |
| / | | | Number of fractions/number of days |
| / | | | Treatment status (*completed, discontinued, etc.*) |
| | | | **Narrative includes:** |
| / | | | Treatment tolerance |
| | | / | Tumor response |
| / | | | Follow-up plan |
| / | | | cc's to referring physicians |
| **Comments:** | | | |

*Worst* *(circle only one)* *Best*

**E. FOLLOW-UP** **1 2 3 4 5**

| Yes | No | N/A | |
|---|---|---|---|
| / | | | First follow-up within 4-6 weeks of treatment completion |
| / | | | Evidence of on-going follow-up by radiation oncologist |
| / | | | Evidence of on-going follow-up by referring physician and/or correspondence regarding patient status |
| | | | Other: *Specify* |
| **Comments:** | | | |

*Worst* *(circle only one)* *Best*

**F. TREATMENT FLOW SHEET / TREATMENT RECORD** **1 2 3 4 5**

| Yes | No | N/A | |
|---|---|---|---|
| Daily treatment record is: | | | |
| | | | Satisfactory |
| | | | Unsatisfactory *(Specify)* |
| | | | Missing items: (*Describe)* |
| | | | Other: |
| **Comments:** | | | |

## G. PORT FILMS / ELECTRONIC IMAGES

*Worst* *(circle only one)* *Best*
**1 2 3 4 5**

| Yes | No | N/A | |
|---|---|---|---|
| / | | | At least every 5-10 treatments |
| | | / | When field changes were made or No field changes were made |
| / | | | Weekly verification of IMRT- If yes, how? |
| / | | | Signed/initialed/dated by radiation oncologist |
| | | | Other: *Specify* |

**Comments:**

## H. TREATMENT PLANNING SIMULATION

*Worst* *(circle only one)* *Best*
**1 2 3 4 5**

| Yes | No | N/A | |
|---|---|---|---|
| | | / | None |
| | | / | Conventional simulation |
| / | | | CT simulation |
| | | / | Diagnostic CT planning |

**Comments:**

## I. ISODOSE DISTRIBUTION PLAN

*Worst* *(circle only one)* *Best*
**1 2 3 4 5**

| Yes | No | N/A | |
|---|---|---|---|
| / | | | Present in chart |
| / | | | Signed and dated by both the physician and physicist (within one week of initiation of treatment) |
| | | / | Documentation of heterogeneity corrections |
| | | | Used correctly for dose calculation |

**Comments:**

## J. IMRT DOSIMETRY

*Worst (circle only one) Best*
**1 2 3 4 5**

| Yes | No | N/A | |
|---|---|---|---|
| / | | | Documentation includes: delivered doses to volumes of target and non-target tissues, in the form of dose volume histograms and representative cross sectional isodose treatment |
| / | | | Inverse planning performed |
| / | | | Accuracy of dose delivery documented by irradiating a phantom containing either calibrated film to sample the dose distribution or an equivalent measurement system to verify that the dose delivered is the dose planned. In addition, the dose to a small region should be verified using an ionization chamber or other appropriately calibrated measurement device. |
| **Comments:** | | | |

## K. BRACHYTHERAPY

*Worst (circle only one) Best*
**1 2 3 4 5**

| Yes | No | N/A | |
|---|---|---|---|
| / | | | Written directive |
| / | | | Documentation of radiation safety survey |
| | | / | Post Implant dosimetry (seed implant) |
| | | / | If **Cervix** case, did patient receive an implant (LDR or HDR) |
| | | | Other: |
| **Comments:** | | | |

## L. CHART and PHYSICS DOCUMENTATION

*Worst (circle only one) Best*
**1 2 3 4 5**

| Yes | No | N/A | |
|---|---|---|---|
| / | | | Diagrams and/or photos of fields documented in the chart |
| / | | | Diagrams and/or photographs of fields labeled (name, date, field #) |
| / | | | Weekly physics check documented |
| / | | | Evidence that the physicist examined the chart at the completion of treatment (within 1 week) |
| | | | Other: |
| **Comments:** | | | |

**Additional Comments:**

**Checklist**

1. **Policy and Procedures documents including:**

| | | | | | |
|---|---|---|---|---|---|
| A. | Time Out Policy | ◉ Yes | ○ No | ○ Does not apply | Comments: |
| B. | Contrast Policy | ◉ Yes | ○ No | ○ Does not apply | Comments: |
| C. | Imaging Portal and IGRT | ○ Yes | ◉ No | ○ Does not apply | Comments: |
| D. | Disaster Plan | ○ Yes | ◉ No | ○ Does not apply | Comments: |
| E. | Infection Control | ○ Yes | ◉ No | ○ Does not apply | Comments: |

**Rating Scale**

A four-point rating scale has been established for each category on the data collection forms. It is essential that only one numerical score be checked for each category. A score of 3 is given if compliant in a particular category. A score of 4 signifies excellent or outstanding performance. Scores that are 1, 2, or 4 will require a comment. Scores of 3, comments are optional.

*Non-Compliant=1 Minor Deviation=2 Compliant=3 Compliant Plus=4*

○ 1 ○ 2 ○ 3 ○ 4

2. **QA and CQI Documents including:**

| | | | | | |
|---|---|---|---|---|---|
| A. | Chart Rounds | ◉ Yes | ○ No | ○ Does not apply | Comments: |

| | | | | |
|---|---|---|---|---|
| B. M&M | (•) Yes | ( ) No | ( ) Does not apply | Comments: |
| C. Focus Studies | (•) Yes | ( ) No | ( ) Does not apply | Comments: |
| D. Internal Outcome | (•) Yes | ( ) No | ( ) Does not apply | Comments: |
| E. Physician Peer Review Documentation | (•) Yes | ( ) No | ( ) Does not apply | Comments: Prior last site visit, ret |
| F. Physicist Peer Review Documentation | ( ) Yes | (•) No | ( ) Does not apply | Comments: I w ill defer to the phy |

**Rating Scale**

A four-point rating scale has been established for each category on the data collection forms. It is essential that only one numerical score be checked for each category. A score of 3 is given if compliant in a particular category. A score of 4 signifies excellent or outstanding performance. Scores that are 1, 2, or 4 will require a comment. Scores of 3, comments are optional.

*Non-Compliant=1 Minor Deviation=2 Compliant=3 Compliant Plus=4*

( ) 1 ( ) 2 ( ) 3 ( ) 4